DOCUMENT RESUME

ED 331 394 HE 024 451

TITLE	Substance Abuse Curriculum Development in Family Medicine: An Instructors' Manual in Two Parts.
INSTITUTION	Society for Teachers of Family Medicine, Kansas City, MO.
SPONS AGENCY	National Inst. on Alcohol Abuse and Alcoholism (DHHS), Rockville, Md.; National Inst. on Drug Abuse (DHHS/PHS), Rockville, Md.
REPORT NO	PH275
PUB DATE	89
CONTRACT	ADM-281-87-0002
NOTE	102p.; For related documents, see HE 024 447-452
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	*Curriculum Development; Faculty Development; *Family Practice (Medicine); Higher Education; *Institutes (Training Programs); *Medical Education; Program Evaluation; *Substance Abuse

ABSTRACT

This instructor's manual is a practical guide to a faculty development training program on substance abuse within family medicine emphasizing a meshing of individual curriculum projects by participants with group instruction and support. Organized into two parts the manual describes the training program in detail in Part 1 and provides 10 actual curriculum examples in Part 2. The training program description includes a section on how to use the manual, an exposition of the program's philosophy, suggestions for evaluation, a list of the faculty resources materials and facilities needed to run the program, suggestions for adapting the program, and practical hints for a successful program. The curriculum examples in Part Two are grouped according to educational level including undergraduate (e.g., improving early diagnosis of substance abuse by medical students), residency (e.g., the impaired health professional), faculty (e.g., a curriculum in substance abuse for family practice faculty), and two applicable to all levels (e.g., how to stay sober and serene in dealing with alcoholic patients). Each curriculum is outlined listing such elements as rationale, objectives, activity sequences, instructional resources, evaluation strategies, hints to the instructor, and an appendix of key materials. (JB)

****
*   Reproductions supplied by EDRS are the best that can be made   *
*   from the original document.   *
****

HE
ED331394

SUBSTANCE ABUSE CURRICULUM DEVELOPMENT IN FAMILY MEDICINE:

AN INSTRUCTORS' MANUAL IN TWO PARTS

BEST COPY AVAILABLE

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it

☐ Minor changes have been made to improve reproduction quality

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

HE024

**The Society of Teachers of Family Medicine
8880 Ward Parkway
Kansas City, Missouri 64114**

Based on work supported through contract #ADM 281-87-0002 from the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse

STFM PROGRAM PEOPLE

WORKING COMMITTEE:

Director
Peter G. Coggan, MD
Department of Family Medicine
University of California - Irvine
101 The City Drive South
Orange, CA 92668
(714) 634-5171

Co-Director
Rebecca Henry, PhD
Office of Medical Education Research and Development
Michigan State University
A 202 East Fee Hall
East Lansing, MI 48824
(517) 353-2037

Coordinator
Ardis Davis, MSW
Department of Family Medicine RF-30
University of Washington School of Medicine
Seattle, WA 98195
(206) 543-9425

Administrator
Roger A. Sherwood, CAE
Society of Teachers of Family Medicine
8880 Ward Parkway
PO Box 8729
Kansas City, MO 64114
(800) 274-2237

Advisory Members
Macaran A. Baird, MD, MS
Department of Family Medicine
SUNY Health Science Center
750 E. Adams Street
Syracuse, NY 13210
(315) 473-4437

Antonnette V. Graham, RN, MSW
University Hospitals Health Center
Case Western Reserve University
Department of Family Medicine
2078 Abington Road
Cleveland, OH 44106
(216) 844-3791

Al J. Mooney, MD
311 Jones Mill Rd.
Statesboro, GA 30458
(912) 764-6236

PARTICIPANTS:

Richard L. Brown, MD, MPH
Jefferson Medical College
1015 Walnut St., Suite 401
Philadelphia, PA 19107
(215) 928-8363

Lorne Campbell, Sr., MD
Serenity Recovery Center
232 W. 25 St.
Erie, PA 16544
(814) 452-5556

James N. Finch, MD
Duke University Medical Center
Department Comm/Family Medicine
407 Crutchfield St.
Durham, NC 27704
(919) 471-4421 Ext. 223

Michael F. Fleming, MD, MPH
Department of Family Medicine
University of Wisconsin
777 South Mill St.
Madison, WI 53715
(608) 263-9953

Stephen P. Flynn, MD
Family Practice Center
Fairview General Hospital
18200 Lorain Ave.
Cleveland, OH 44111
(216) 476-7086

Robert H. Funke, MD
Kingsport Family Practice Center
201 Cassell Drive
Kingsport, TN 37660
(615) 246-6202

Benjamin Goodman, Jr., MD
Medical Arts Clinic
24 Second Ave. NE
Hickory, NC 28601
(704) 328-2231

Anton J. Kuzel, MD
Department Fam. Practice
Medical College of Virginia
Fairfax Family Practice Center
3650 Joseph Siewick Dr. 400
Fairfax, VA 22033
(703) 391-2020

Jerome Schulz, MD
Family Practice Residency Training Program
St. Paul-Ramsey Medical Center
640 Jackson St.
St. Paul, MN 55101
(612) 221-3540

J. Paul Seale, MD
Dept. of Family Practice
University of Texas Health Science Center
7703 Floyd Curl Drive
San Antonio, TX 78284
(512) 270-3911

CONSULTANTS:

Carole J. Bland, PhD
Department of Family Practice and Community Health
6-240 Phillips Wangensteen Bldg.
516 Delaware St. SE
Box 381 UMHC
Minneapolis, MN 55455
(612) 624-9143

Raymond C. Anderson, MD
Arms Acres
PO Box X
Carmel, NY 10512

ACKNOWLEDGEMENTS

Sincere thanks and appreciation are extended to the staff of the Society of Teachers of Family Medicine whose work assured the smooth running of the program. Of particular note is Chris Morlang, who spearheaded the innumerable circulations of materials, and Julie Mierau, who coordinated the editing and typesetting.

TABLE OF CONTENTS

Part I

Page

LIST OF APPENDICES AND FIGURES FOR PART I ... 2

INTRODUCTION ... 3

HOW TO USE THIS MANUAL ... 3
- Replication of Entire Program
- Modified Version of Program
- Replication of Selected Elements of Program
- Specific Curriculum Examples in Substance Abuse
- Practical Advice on Tough Curriculum Issues

UNDERLYING PHILOSOPHY OF TRAINING PROGRAM ... 4

THE TRAINING PROGRAM ... 4
- Overview
- Working Committee
- Program Objectives
- Participant Characteristics and Selection Process
- Program Implementation

EVALUATION OF THE TRAINING PROGRAM ... 9

FACULTY, RESOURCES, MATERIALS AND FACILITIES NECESSARY TO RUN THE PROGRAM ... 11
- Resources
- Materials
- Facilities

ADAPTING THE TRAINING PROGRAM ... 11

FURTHER HINTS FOR A SUCCESSFUL PROGRAM ... 12

REFERENCES ... 12

Part II

SUMMARY OF CURRICULUM EXAMPLES ... 19

PRACTICAL ADVICE ON TOUGH CURRICULUM ISSUES ... 19

TEN CURRICULUM EXAMPLES (grouped by educational level of learners)

UNDERGRADUATE

Funke, Robert H.
"Promoting Medical Student Recognition of Chemical Dependency" ... 21

Brown, Richard L.
"Improving Early Diagnosis of Substance Abuse by Medical Students" ... 27

RESIDENCY

Flynn, Stephen P. ... 33
"Alcoholism: Diagnosis and Intervention for Family Physicians"

Goodman, Benjamin W. Jr. ... 43
"The Impaired Health Professional: A Curriculum for PGY-1 Residents"

Seale, J. Paul ... 53
"Planning and Implementing a Part-Time PG-1 Resident Rotation in Substance Abuse"

Campbell, Lorne R. Sr. ... 65
"A One-Week Packaged Flexible Module for Family Practice Residents"

FACULTY

Finch, James ... 75
"A Curriculum in Substance Abuse for Family Practice Faculty"

Kuzel, Anton J. ... 85
"A Brief Intervention Strategy for Faculty Development in Chemical Dependency Syndrome"

ALL LEVELS

Schulz, Jerome E ... 93
"How to Stay Sober and Serene in Dealing with Alcoholic Patients"

Fleming, Michael F. ... 101
"Alcohol and Drug Withdrawal: Medical Management"

Substance Abuse Curriculum Development in Family Medicine

PART I:

A FACULTY DEVELOPMENT TRAINING PROGRAM IN SUBSTANCE ABUSE

LIST OF FIGURES AND APPENDICES FOR PART I

Page

LIST OF FIGURES

Figure 1. Overview of Training Program ... 4

Figure 2. Objectives of Training Program ... 5

Figure 3. Instructional Elements of Training Program ... 6

Figure 4. Training Program Objectives Met Through Instructional Elements ... 7

Figure 5. Working Comittee (WC) Activities ... 8

Figure 6. Participants' Activities ... 9

Figure 7. Program Objectives Assessed Through Evaluation Elements ... 9

Figure 8. Specific Evaluation Strategies and Outcome Measures ... 10

APPENDICES

A. Sample Format for Final Curriculum Project Write-Ups ... 13

B. Sample Activity Sequence for Group Instructional Meeting #1 ... 14

C. Willingway Hospital ... 15

D. References for Learning Materials and Teaching Resources ... 15

INTRODUCTION

This manual was developed through a federal contract to the Society of Teachers of Family Medicine (STFM), the purpose of which was to demonstrate a model substance abuse faculty development training program in family medicine. It was developed from a combination of what worked well in STFM's initial experience with the training program in combination with suggested changes to enhance the success of future programs based on the underlying model. A description of the STFM pilot test of this model training program can be found in a separate document submitted as one of the final reports to the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse.

The objectives of the model training program are varied and broad reaching with exciting potential for impacting both the program participants as well as the institutions from which they come. The program fosters and facilitates participants' knowledge and skills in four areas of substance abuse faculty enrichment: clinical, medical education, administration, and academic/professional. It creates a network among the participants designed to outlive the program, while at the same time increasing faculty development activities at the individual home institutions of participants. Moreover, it enables participants to describe their curriculum development work in a scholarly manner, the end product of this being separate curriculum examples bound into a manual for use by each other and by educators elsewhere.

The major characteristics of the training program are a meshing of individual curriculum projects by participants with group instruction and support to produce a process of active sharing and collaboration. Too often, faculty educators with a special interest in a specific field such as substance abuse suffer from isolation and lack of input and encouragement from others. This produces a barrier which inhibits not only the development of teaching and research in special areas but, more importantly, exhausts once-eager faculty members. **This program's focus on the dynamic processes of network development makes it clearly unique from other models of faculty development where the emphasis is on tangible end products.**

HOW TO USE THIS MANUAL

The goal of this manual is to be a practical guide to a specific method of faculty development. It is intended to be of use to individuals who want to replicate the entire program. Perhaps more applicable to most of its users, it is also intended to be helpful to individuals who want to modify the program or select specific curriculum examples in substance abuse.

Replication of Entire Program

The whole program can be replicated with substance abuse as the specific field of interest, in which case the entirety of Part I of this manual may be used. However, this same program could be conducted with any other topic of special interest. For readers with this in mind, Part I of the manual will provide an understanding of the framework and process of the program.

Modified Version of Program

Many readers may find the entire program impractical for their needs or resources. In this case, the features of the program which are essential to accomplishing the program objectives at a minimum level have been summarized in the section on "Adapting the Training Program."

This may be the most valuable section to educators in family medicine, since the program has been designed to be easily adapted to fields other than substance abuse and can be applied with as few as two participants.

Replication of Selected Elements of the Program

The program's major instructional elements can be used independently. Readers interested in this should turn to the section on "Program Implementation." This might be of particular use to readers who want to focus on specific strategies such as group instruction, applied learning exercises or mechanisms for sharing information and resources on a given topic.

Specific Curriculum Examples in Substance Abuse

The STFM training program participants produced separate curricula in substance abuse which collectively cover all educational levels, address a variety of mini-topics, and demonstrate a wealth of instructional techniques and evaluation strategies. These can be found in Part II of this manual, each with its own appendix of key materials. These examples illustrate state-of-the art substance abuse teaching in family medicine today.

Practical Advice on Tough Curriculum Development Issues

Part II of the manual also summarizes the experience of the STFM program participants with common, difficult curriculum development issues likely to arise for anyone undertaking substance abuse curriculum development in family medicine. Although these stem directly from the implementation of the substance abuse curriculum, the suggestions may be applicable to other topics not in the mainstream of the medical school or residency curriculum.

UNDERLYING PHILOSOPHY OF TRAINING PROGRAM

This training program is founded upon other more traditional faculty development models which incorporate instructional components along with two components important in higher education: organizational development and personal development.(1) Faculty development philosophy in family medicine has typically adhered to the inclusion of such innovations, but over the past decade has broadened in scope and purpose.(2)

Faculty development is much more than a series of workshops. It requires the planned application of established principles and concepts of adult learning, educational psychology, and instructional science. To ensure a quality outcome, faculty developers must design a program that is both specific and comprehensive in scope, and educationally sound. In keeping with these precepts, faculty development models in family medicine today emphasize the following principles:(3)

- skill development should attend to the varying needs of faculty from varying institutions;
- life-long vitality is an important goal of faculty development; and
- a process of "socialization" takes place in models which are successful in ensuring vitality.

This training program draws upon a model possessing qualities in accordance with the above principles. It is specific in that a portion of the activities are designed to meet the special needs of each participant through individually designed projects. To this end, the content of the program is determined in part by an assessment of the needs of the participants, from a perspective of their knowledge of the subject area, their sophistication in curriculum development, and the needs of their home departments or programs. Such learner-centered approaches have been described as highly suited for adult learners (4) and ideal for educating medical educators.(5)

Moreover, the training program possesses dynamic network-building features which are crucial for sustained vitality and enhanced socialization. This element is essential if true faculty enrichment is to occur. The completion of any faculty development program should not be viewed as an end point but, rather, as the initial step in a continuing commitment to academic excellence, whatever the field of endeavor.

THE TRAINING PROGRAM

Overview

FIGURE 1. OVERVIEW OF TRAINING PROGRAM

Program Objectives	*Instructional Elements*	*Evaluation Elements*
Foster Development of Knowledge and Skills in Four Areas; - Clinical - Medical Education - Administration - Academic/Professional	I. Group Instruction (off site) II. Individual Curriculum Project (on site) III. Individual Clinical Training (on and off site) IV. Resource Exchange (on and off site)	I. Increase in Clinical Competence II. Curriculum Project Performance III. Curriculum Project Dissemination IV. Program Impact on Participants
Create Network Among Participants to Outlive Program	V. Socialization Activities (on and off site) I, IV Above	V. Network Formation
Increase Faculty Development Activities at Home Institutions	I, II, Above	VI. Program Impact on Institutions
Promote Scholarships through Presentation and Publication of Curriculum Development Work	I, II, IV Above	II, III Above
Produce a Manual of Pilot-Tested Curriculum Examples	I, II Above	II, III Above

Off site = workshops presented to all participants away from their home institutions
On site = activities at the participants' home institutions

Program Administration

WORKING COMMITTEE

The Working Committee runs the training program. Ideally, the members of the committee have broad collective expertise and are sufficient in number to allow both administrative and advisory levels of functioning within the committee as outlined below. However, for many programs, this is either impossible or impractical. The key qualities necessary for a working committee then are, first and foremost, interest and enthusiasm for the program, and secondly, clinical and/or academic expertise in substance abuse.

The primary functions of the working committee are to:

1) advise participants on the development and execution of their curriculum projects (to include making site visits);
2) evaluate the ongoing program's progress, make and implement revisions;
3) conduct a terminal evaluation of the program;
4) determine and delegate program implementation policy;
5) develop instructors' manual or guide and describe curriculum examples developed by participants;
6) facilitate networking among the participants;
7) facilitate participants' socialization to the academic field of substance abuse.

WORKING COMMITTEE CHARACTERISTICS

The STFM program's working committee was particularly successful it two ways: it functioned well internally, and it was efficient and productive in completing its tasks. Below are the major characteristics of this working committee, presented here as guidelines for the formation and functioning of other working committees.

The following components must be represented in the committee:

- Family Physician
  - -Clinical interest and expertise
  - -Academic interest and expertise
  - -Representing various educational levels
- Behavioral Science in Family Medicine
- Curriculum Design and Evaluation
- Substance Abuse Curriculum Development
- Administration and Organization

TWO LEVELS OF ORGANIZATION

The Working Committee functioned at two levels designed to meet the needs of day-to-day administration and long-term policy making.

- Administrative Level
  - - Director
  - - Co-Director
  - - Coordinator
  - - Administrator
- Advisory Level
  - - Family physician consultant
  - - Behavioral science consultant
  - - Curriculum design and evaluation consultant

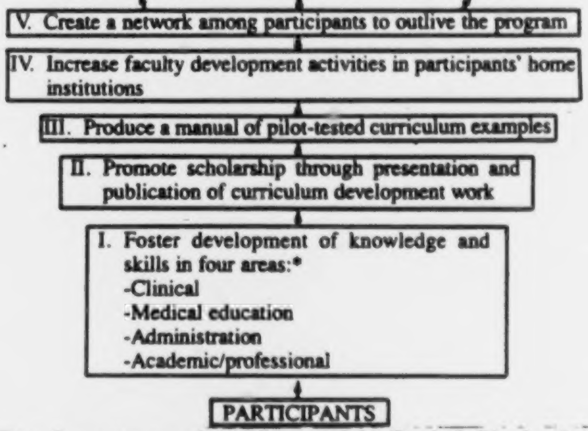
KEYS TO SUCCESS

- Primary tasks and functions of the working committee are carried out at the administrative level, drawing on the advice and expertise of the advisory level. Some members may work on both levels. A willingness to cross administrative and advisory boundaries is important.
- Past history of collaboration and consideration of how personalities will mesh.
- Successful working relationships among administrative-level people (especially between director(s) and coordinator) are crucial for completion of tasks and for creating a productive, supportive ambience.
- Members at the administrative level MUST be empowered to make day-to-day decisions without reference to the whole working committee. (In the STFM committee, this was especially true of the power given the Director and Coordinator).
- Committee members contribute to the program by teaching selected segments at instructional meetings to model the academic role.

Program Objectives

The program begins with a narrow focus on participants' own knowledge and skills. Through the training process, the objectives broaden in scope until finally a self-sustaining network is created. Below, is a diagram illustrating the relative breadth and progression of the program objectives.

FIGURE 2. OBJECTIVES OF TRAINING PROGRAM


V. Create a network among participants to outlive the program
IV. Increase faculty development activities in participants' home institutions
III. Produce a manual of pilot-tested curriculum examples
II. Promote scholarship through presentation and publication of curriculum development work
I. Foster development of knowledge and skills in four areas:*
-Clinical
-Medical education
-Administration
-Academic/professional
PARTICIPANTS

*These four areas are adapted from work by Carole J. Bland and colleagues (see reference number 3).

PARTICIPANT CHARACTERISTICS AND SELECTION PROCESS

PARTICIPANT CHARACTERISTICS

Optimally, participants entering this model program should possess:

- interest and enthusiasm for substance abuse teaching and curriculum development;
- departmental or institutional support for participation in such a program and long-term commitment to the institution;
- diversity in the nature of their responsibilities, experiences, and expertise;
- widespread geographic representation (if program is regional or national);
- team-building skills, as evidenced by past work on committees, task forces, etc.; and
- interest in or evidence of scholarship.

While it may not be possible to recruit individuals with this complete range of characteristics, the first two are deemed essential for a successful program. The remainder lend themselves to network building, and thus are desirable, but not absolutely necessary.

PARTICIPANT SELECTION PROCESS

The following recommendations address criteria for selecting participants for a formal program. Some of these may not be necessary for a smaller, less structured program.

A COMPETITIVE APPLICATION PROCESS

To ensure that participants meet the two necessary requirements above, it is best to use a competitive application process for selection. Through this mechanism, interest and enthusiasm can be established. A written statement of institutional commitment (ie, letter of support from the departmental chairman or program director) can be obtained. An application can also require the candidate to submit a brief outline for a curriculum project. This exercise will provide some demonstration of interest and enthusiasm and assist in maintaining a balance in the program since an appropriate mix of projects can be ensured.

TIMING OF APPLICATION PERIOD

"Word of mouth" advertising through regional or national meetings is effective. Thus, timing the application deadline to follow meetings permits recruitment from a targeted group.

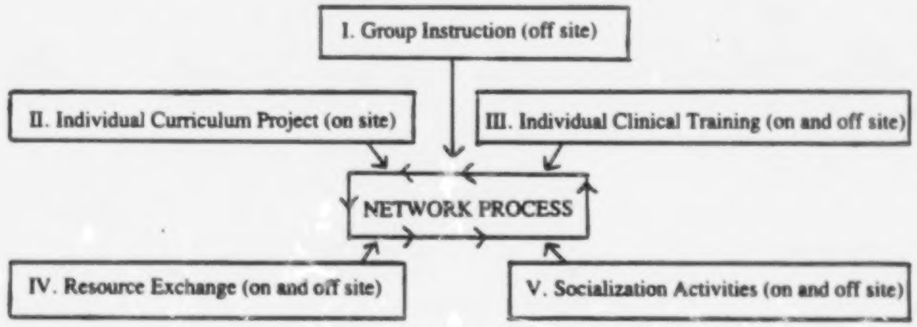
Program Implementation

INSTRUCTIONAL ELEMENTS

The five instructional elements of the program are illustrated below. The network process developed through these five instructional elements is central to the long-term success of this faculty development training model. It is also one of the most instructive features of this training program. Participants learn as much or more from interacting in this network as they do from the five instructional elements.

Each of the five instructional elements is briefly discussed below. This section also includes a more detailed description of specific strategies recommended within each of these and a discussion of network development.

FIGURE 3. INSTRUCTIONAL ELEMENTS OF TRAINING PROGRAM


I. Group Instruction (off site)
II. Individual Curriculum Project (on site)
III. Individual Clinical Training (on and off site)
NETWORK PROCESS
IV. Resource Exchange (on and off site)
V. Socialization Activities (on and off site)

GROUP INSTRUCTION

Meetings of the working committee and participants distributed throughout the program provide most of the formal instruction. Through these meetings, the process of networking is fostered. In addition, they serve as a forum for tracking participants' curriculum projects and clinical training, and for some of the socialization and resource exchange activities.

INDIVIDUAL CURRICULUM PROJECT

All participants enter the training program with specific curriculum projects in mind. Through the program, their ideas are further developed, pilot tested, refined,and prepared for implementation. The curriculum project provides a focus for participants and represents their greatest investment in the program.

INDIVIDUAL CLINICAL TRAINING

Participants are responsible for augmenting clinical knowledge and skills through individual readings, audiovisual materials, local treatment center experiences,and other methods. Participants are guided in their choices through a brief needs assessment conducted at the outset of the program. In addition, a required clinical experience at a treatment center should be part of each participant's clinical training.

RESOURCE EXCHANGE

The diversity in background of both participants and their institutions suggests that no single set of learning materials and resources will meet each of the participant's needs. Thus, a formal mechanism to permit participants to build their own collections of resource materials is necessary from the outset.

SOCIALIZATION ACTIVITIES

Socialization is an important concept in this training program. The term refers to a process whereby faculty development trainees identify with the professional and academic values of a specific field, in this case substance abuse. The degree to which participants identify with the field is dependent upon their personal levels of commitment. Successful faculty educators in substance abuse must acquire, however, a minimum level of identification with the specialty sufficient to prevent isolation and eventual burn-out.

All five instructional elements combine to meet the program objectives. However, as seen below, group instruction and the individual curriculum projects are the most crucial in meeting all of the program objectives.

FIGURE 4. TRAINING PROGRAM OBJECTIVES MET THROUGH INSTRUCTIONAL ELEMENTS

Program Objectives	*Instructional Elements*
Foster Development of Knowledge and Skills in Four Areas: - Clinical - Medical Education - Administration - Academic/Professional	I. Group Instruction (off site) II. Individual Curriculum Project (on site) III. Individual Clinical Training (on and off site) IV. Resource Exchange (on and off site)
Create a Network Among Participants to Outlive the Program	I. and IV. above V. Socialization Activities (on and off site)
Increase Faculty Development Activities at Home Institutions	I. and II. Above
Promote Scholarship through Presentation and Publication of Curriculum Development Work	I., II., and IV. Above
Produce a Manual of Pilot-Tested Curriculum Examples	I. and II. Above

IMPLEMENTATION FRAMEWORK

The specific instructional strategies and recommendations arising from the STFM program are listed below.

GROUP INSTRUCTION

Agendas for Meetings

- Agendas for group meetings must incorporate time for the following activities:
  - update and discussion of participants' curriculum projects which can be streamlined by:
    a) using a small group format for presentation and discussion AFTER the first meeting (where the large group format is preferable);
    b) circulating participants' presentations in written form prior to the meeting; and
    c) imposing clear structure on content and length of project presentations
  - exchange and discussion of resources
  - clinical instruction
  - curriculum development instruction
  - informal breaks
  - socialization activities: discussion of local and national meetings, discussion of grant opportunities, grant writing, and submission deadlines.
- The agenda for the FIRST meeting must allow sufficient time for:
  - collection and review of needs assessment information
  - review of format for final curriculum project write-ups (see Appendix A for sample format)
  - discussion of requirements and administrative details
  - provision of ample discusison time for discussion of individual curriculum projects within the large group;
  - social "ice-breaking" and team-building activities.

  (See Appendix B for a Sample Meeting Activity Sequence for Meeting #1. This provides a framework which can be adapted for the remaining meetings.)
- The agenda for the last meeting should be designed in part by the participants to allow them a specific opportunity to work together and to best meet their own final program needs.

Length and Timing of Meetings

- The first meeting requires more time than the rest.
- Three days for the first meeting and two days for subsequent meetings are recommended.
- Provision of adequate time for networking and sharing should not be compromised. Crammed, hectic meetings do not promote the learning and networking process.
- Meetings must be timed in accordance with the phases of participants' projects. (See Tables 5 and 6). Consideration of the academic year cycle and the ability to complete pilot testing must be taken into account.

Needs Assessment

- A limited assessment of participants' incoming needs is a prerequisite in determining content of clinical and curriculum development teaching sessions. Simple recommended steps are:
  - A short questionnaire mailed prior to the first meeting to elicit each participant's content needs and areas of expertise.
  - At the first group meeting, (ie, one hour) review the questionnaire results and determine consensus for specific content of instruction.

Teaching Strategies

The following teaching strategies for group instruction are recommended:

- Experiential strategies (role play, simulated patient or clinical videotape reviews)
- Guided clinical discussions and interactive lectures
- Demonstration of a variety of teaching strategies in the teaching sessions
- Tapping participants' expertise for teaching wherever possible

INDIVIDUAL CURRICULUM PROJECT

Working Committee's Role

- Each participant should be assigned one working committee member as an advisor to assist in the completion of the curriculum project.
- Working committee advisors should act as conduits to the expertise of the larger group rather than providing exclusive advice.
- A working committee member (preferably the advisor) should make at least one site visit to each participant's institution at an appropriate time.
- The working committee should devise a specific format (Appendix A) for the written end products expected of participants. This should be distributed and discussed in detail at the first group meeting.
- The working committee should ensure that the scope of each participant's project is feasible and consistent with the time frame and requirements of the program. The working committee will frequently be in the postition of focusing the enthusiastic participant on to an achieveable goal.

Participant's Role

- Projects should be learner-centered and learner- directed, drawing on the advice and expertise of the working committee as needed.

INDIVIDUAL CLINICAL TRAINING

- Provide participants with a "textbook" and clinical bibliography prior to or at the first group meeting.
- Recommend individual clinical training at home sites, the extent and content of which depends on the participants' own areas of expertise and needs.
- Require a one-week clinical experience at an alcohol and drug abuse residential treatment center. A pre-post test associated with this is recommended.

RESOURCE EXCHANGE

At Group Meetings

- Participants build their own resource collection in an empty three-ring binder provided them at the first meeting.
- Unlabeled notebook dividers allow individual participants to label their own sections.
- Provide a forum for discussion and sharing of learning materials and resources at each meeting.
- Display all materials brought to the meetings through the duration of the meetings.
- Following each meeting, copy, three-hole punch, and circulate all materials brought to the meeting (for books and audiovisual materials, circulate references only) among all working committee members and participants.

Between Meetings

- Coordinate circulation of other resources and materials of interest. This is an ongoing process best coordinated through one person. These may be three-hole punched for inclusion in the binders, if so desired.

SOCIALIZATION ACTIVITIES

- Heighten participants' awareness of events, services, and organizations pertinent to substance abuse through:
    - circulating information about upcoming regional or national meetings, major substance abuse organizations, relevant journals, and information services;
    - arranging for participants' names to be added to clearinghouse and educational service mailing lists and to relevant federal and private institution mailing lists.
- Toward the end of the program, form a network of participants and working committee members. Allow participants to take the lead as much as possible. (In the STFM program, this was done through the formation of a Substance Abuse Working Group within STFM.)
- Assign responsibiity for the last group meeting agenda to participants thereby engendering networking.

IMPLEMENTATION PROCESS

The timing of the key implementation activities is summarized on the following pages. Two years is the optimum time for implementation of the entire program. Both years are divided into three phases (Phases 1-3 for Year 1 and Phases 4-6 for Year 2), each of which ends with a group instructional meeting. The program framework is organized around and anchored by these five group instructional meetings.

The following figures separate the activities of the working committee from those of the participants. The participants' activities are, for the most part, grouped under two major areas: individual curriculum projects and individual clinical training. These two areas, particularly the curriculum project, form the major portion of the participants' activities over the course of the training program.

FIGURE 5. WORKING COMMITTEE ACTIVITIES

YEAR 1	**Phase 1** (4 mos.)	**Phase 2** (3 mos.)	**Phase 3** (5 mos.)
	Planning: Selection/formation of Working Committee; **Working Committee Meeting:** Overall program plan; Plan first meeting. **Selection of Participants** **Initial Contact of Participants** Needs Assessment; First meeting info. FIRST MTG.	**Evaluate 1st Mtg. & Plan for 2nd*** **Socialization:** Circulate info.; Put names on lists. **Resource Exchange:** Copy and circulate materials exchanged at meeting and others accumulated between meetings SECOND MTG.	**Evaluate 2nd Mtg. and Plan for 3rd*** (Resource exchange cont.) THIRD MTG.
YEAR 2	**Phase 4** (3 mos.)	**Phase 5** (3 mos.)	**Phase 6** (6 mos.)
	Evaluate 3rd Mtg. and Plan for 4th * Make Site Visits (Resource exchange cont.) FOURTH MTG.	**Evaluate 4th Mtg. and Plan for 5th*** (Resource exchange cont.) **Assist with formal network formation** FIFTH MTG.	**Evaluate** Learner & Program Evaluation; Analyze interpret data; **Prepare manual of curriculum projects including review and critique by participants**

*Evaluation and planning occur on the day after each meeting

FIGURE 6. PARTICIPANTS' ACTIVITIES

YEAR 1	**Phase 1**	**Phase 2**	**Phase 3**
	(4 mos.)	(3 mos.)	(3 mos.)
Major Areas:			
Curriculum Project	Idea development and prepare to present at 1st mtg.	Develop curriculum plan and prepare to present at 2nd mtg.	Pilot test curriculum component and prepare to present at 3rd mtg.
Clinical Training		Required Clinical Training (one week) Individual Activities	(Required Clinical Training cont.) (Individual Activities cont.)
Other	FIRST MTG.	SECOND MTG.	THIRD MTG.
Year 2	**Phase 4**	**Phase 5**	**Phase 6**
Major Areas:	(3 mos.)	(3 mos.)	(6 mos.)
Curriculum Project	Prepare for and receive site visit Refine curriculum component and prepare to present at 4th mtg. Write draft of curriculum project	Complete write-up Begin implementation of component	(Implementation of component cont.)
Clinical	(Individual Activities cont.)	(Individual Activities cont.)	
Other	FOURTH MTG.	FIFTH MTG.	Complete Evaluation instruments and review manual

EVALUATION OF THE TRAINING PROGRAM

Evaluation of the training program is conducted by assessing the attainment of the program objectives. There are six separate evaluation elements designed to do this, as presented in Figure 7 below.

Recommended specific evaluation strategies and outcome measures for each evaluation element are provided in Figure 8.

FIGURE 7: PROGRAM OBJECTIVES ASSESSED THROUGH EVALUATION ELEMENTS

Program Objectives	**Evaluation Elements**
Foster Development of Knowledge and Skills in Four Areas: - Clinical - Medical Education - Administration - Academic/Professional	I. Increase in Clinical Competence II. Curriculum Project Performance III. Curriculum Project Dissemination IV. Program Impact on Participants
Create Network Among Participants to Outlive Program	V. Network Formation
Increase Faculty Development Activities at Home Institutions	VI. Program Impact on Institutions
Promote Scholarship through Presentation and Publication of Curriculum Development Work	II. and III. Above
Produce a Manual of Pilot-Tested Curriculum Examples	II. and III. Above

FIGURE 8. SPECIFIC EVALUATION STRATEGIES AND OUTCOME MEASURES

Evaluation Element	Specific Strategies	Outcome Measures
I. Increase in Clinical Competence	Pre-Post knowledge and skills test in conjunction with required clinical experience in a residential treatment center	Clinical competence assessed by treatment center medical staff and test measures
	Pre-Post attitude test (Appendix D)	Attitude measure changes
	End-of-Program Questionnaire (completed by participants)	Ratings of value of the following in meeting clinical goals for program: - instructional elements - specific instructional strategies - instructional materials
II. Curriculum Project Performance	Working Committee Evaluation	Tracking progress of projects through group meetings Project Completion
	End-of-Program Questionnaire	Ratings of value of the following to aiding in completion of project: - instructional elements - specific instructional strategies - instructional materials
III. Curriculum Project Dissemination	End-of-Program Interview with Participants	Plans for or completion of presentations or publications on curriculum project
IV. Program Impact on Participants	End-of-Program Questionnaire	Ratings of value of overall program to participants' career advancement
	End-of-Program Interview with Participants	Before and after program involvement in: - teaching (# hours and # learners) - institutional and community committees - interdepartmental teaching & research - specialty organizations (national, regional, and local)
V. Network Formation	Working Committee Documentation and Evaluation	Existence of viable network by end of program Specific tasks and endeavors undertaken by network by end of program Network leadership established by of end of program
VI. Program Impact on Institution	End-of-Program Questionnaire	Before and after involvement in teaching faculty: - # hours - # faculty
	End-of-Program Interview with Participants	# faculty involved in teaching with participant before and after program Perception of department/program attitude change
	End-of-Program Interview with Chairmen	Perception of department/program attitude change Specific activities participant is doing at end of program which he/she was not doing previously Scholarly contributions by participant to department and institution

FACULTY, RESOURCES, MATERIALS, AND FACILITIES NECESSARY TO RUN THE PROGRAM

Resources

Personnel

The following are recommendations from the STFM program experience:

- Working committee members' time
  - Director and Co-Director at 10%
  - Administrator at 10%
  - Coordinator at 40% - 50%
  - Advisory level members compensated as consultants with honoraria for meeting time
- Consultants
  - In addition to internal working committee advisory members, at least one outside consultant with expertise in educational design and evaluation is mandatory in the development of instructional materials
- It is desirable to pay participants honoraria (in addition to per diem) for time spent at group instructional meetings

Travel

- Transportation and accommodations for working committee to conduct an initial planning meeting (2 days)
- Transportation and accommodations for group instructional meetings (depending on location of learners and working committee members)
- Working committee members need an extra day of travel time and accommodations added on to each group instructional meeting for debriefing and planning

Printing

- Costs must be incorporated into the budget for the printing of the manual developed in the program.
- Before final printing, word processing capability is mandatory to ensure easy transfer of information into a common format.

Telephone

- The emphasis on networking in this model and geographic spread of participants may be reflected in high telephone costs.

Postage

- Postage costs to cover resource and material circulation can be considerable.

Materials

Photocopying

- Photocopying funds are necessary to copy the large quantity of materials shared and circulated.

Written Learning Materials

- Three-ring binders are needed (one for each working committee member and participant) in which to accumulate readings and references;
- One or two "texts" are suggested to prepare the participants for the first group instructional meeting. In the STFM program, the "Family Medicine Curriculum Guide to Substance Abuse" was used for this purpose. This was given an average rating by the STFM program participants. A higher rating was received by the AMSAODD Review Course syllabus. (See Appendix D for these and other references to materials found useful by the STFM program participants.)

Audiovisual Learning Resources

- Appendix D refers to two audiovisual resources useful for the group instructional meetings. Appendix B illustrates how one of these, "Calling the Shots," was used as an ice-breaker and focus for discussion in the first meeting.

Facilities

Clinical Training Site

- Local residential treatment centers may be available to participants, and thus may be desirable. It is important that a local site provide treatment for both alcohol AND other drug abuse, and that the site have some experience with teaching medical students, residents, physician faculty members, or physicians in practice.
- If no local site is available, one site for this purpose is Willingway Hospital in Statesboro, Georgia. (See Appendix C for further information on Willingway Hospital and the contact person there.)

Group Instructional Meeting Needs

- Any resort or other hotel accommodations
  - one room to accommodate one large table for all participants and a smaller table to display materials shared at the meeting
- Equipment
  - Audiovisual equipment necessary for group meeting teaching sessions (i.e. 16 mm film projector and screen or videotape player and monitor)
  - Slide projector for participants' presentations
  - Overhead projector for participants' presentations
  - Flip chart
  - Blackboard and chalk

ADAPTING THE TRAINING PROGRAM

Essential Process and Instructional Elements

A specific teaching approach leading toward network development is central to the training program. Any adaptation of the program itself must incorporate this concept. The approach, simply put, is the application of sound learning principles: namely, promoting a gradual change from a largely teacher-directed program to a collaborative, learner-directed program with diminishing consultation from the teachers.

In situations where the application of the complete training model described in this manual is inappropriate or constrained by inadequate resources, the framework described in this section will permit the implementation of a modified program which adheres to these principles.

This framework can accommodate any group from small committees within departments or institutions to larger regional or national groups. It lends itself to applications in faculty development, where faculty are geographically spread out or where they are centered in a university or medical school setting.

Minimum Program Framework

The structure of a condensed program using this teaching approach must allow for the following:

1) a MINIMUM of two meetings, the initial meeting to set the expectations and an interim meeting to report on progress and to share within the group; and,

2) a realistic timetable for participants to complete the assigned project.

Once these characteristics are established, the remaining necessary features of a condensed program are:

1) a common theme or topic for the projects (a common interest or reason for participation);

2) a clear understanding among all participants of the timetable and expectations of them;
3) a simple mechanism for sharing and networking among participants (such as the resource exchange described elsewhere in this manual);
4) provision of frequent contact and support throughout the program (telephone contact will suffice); and,
5) circulation of each participant's work among all program members at the end of the program.

TEACHING APPROACH: FACILITATION OF NETWORK DEVELOPMENT

Network development can be facilitated by adhering to key program features as outlined below.

Participant Selection

The participant selection process should ensure interest and enthusiasm of participants through:

- preconceived idea for a project for all participants;
- demonstration of institutional or department/program commitment; and
- competitive application process (where applicable).

Levels of Activity

There are three levels of activity: 1) activities among the working committee; 2) activities among the participants; and, 3) activities facilitating participants' involvement in outside groups.

1) Activities of the Working Committee

* Focus on the participants through having:
  - participants select and direct their own projects;
  - working committee attention devoted to participants' progress; and
  - a needs assessment before determining content for group instructional meetings.
* Provide structure, yet allow flexibility through:
  - group meetings and formative evaluation approaches; and
  - flexibility in participants' use of group meeting time.
* Encourage and assist with "side" projects which emerge in group meetings.
* Employ strategies to ensure participant satisfaction and commitment such as facilitating:
  - technical assistance with writing up projects; and
  - presentations of work at selected regional or national meetings.

2) Activities Among the Participants

* A portion of group time should be spent on participants' projects.
* Exchange of materials and resources is contributed to by both participants and working committee members (working committee to contribute to, not dominate).
* Use participants' expertise wherever possible through:
  - participants' contributions to teaching in group meetings; and
  - participant-directed discussions of projects at group meetings.

3) Activities Facilitating Participants' Involvement in Outside Groups

* Encourage and facilitate participation in other substance abuse professional organizations and activities.
* Encourage and facilitate participation in other primary care substance abuse training activities.
* Encourage and support participants who seek other grant support for continued work in this area.

FURTHER HINTS FOR A SUCCESSFUL PROGRAM

The STFM program succeeded because of the people involved and the atmosphere created by them. This manual has attempted to operationalize qualities and characteristics of the program which not only brought the people together but which also engaged them in a professionally and socially constructive manner.

These "hints" are derived from the somewhat less tangible, important parts of the STFM experience. Although several have been alluded to throughout the manual, they bear repeating.

1) Provision of structured group social time.
   This was important in establishing the atmosphere at group instructional meetings and individual working relationships. At group meetings, at least one dinner was a group dinner. Although other dinners were not specifically planned as such, it was often the desire of most group members to dine together.

2) Working committee members must be eager to learn from participants.
   The STFM Working Committee members were all "experts" in the field of substance abuse or curriculum development, but were frequently confronted with their own shortcomings in knowledge and skills. Of necessity, they became eager to learn from and work with the program participants. This attitude is crucial for the development of group spirit.

3) Flexibility.
   The program must allow for flexibility, while at the same time imposing structure where necessary. Ideally, there is a progressively diminishing structure over time requiring delicate leadership.

4) Selection of Realistic Individual Projects.
   The working committee must ensure from the initial meeting that participants' projects are realistic.Helping participants focus on realistic goals is one of the most critical first steps of the working committee.

5) Increasing Involvement of Participants.
   It is important to foster a feeling of "ownership" of the program and its products by the participants. In the STFM program, participants became increasingly more involved in the direction of the program through a deliberately crafted process.

REFERENCES

1. Bergquist, WH and Phillips, SR: Components of an effective faculty development program. *J Higher Educ*; 46:177-209; 1975.
2. Bland, CJ and Schmitz, CC: Characteristics of the successful researcher and implications for faculty development. *J Med Educ*; 1:22-31; 1986.
3. Bland, CJ (Project Director): A model curriculum to prepare family medicine physicians to assume the role of new faculty members in either university or community-based educational programs. Contract # 240-84-0077 Final Report; 12/28/86; Division of Medicine, Bureau of Health Professions; Health Resources and Services Administration; Department of Health and Human Services.
4. Tough, E: The adult learning project: A fresh approach to theory and practice in adult learning. *Research and Education Series*; #1; Toronto, Ontario Institute for Studies in Education; 1971.
5. Collins, R and Hammond, M: Self-directed learning to educate medical educators. Part II: Why do we use self-directed learning? *Medical Teacher*; 9(4):425-432; 1987.

APPENDIX A

SAMPLE FORMAT FOR FINAL CURRICULUM PROJECT WRITE-UP

(Participant Name)
(Participant Address)
(Participant Phone Number)

TITLE OF CURRICULUM COMPONENT

(Center the title of your component here under this heading)

CONTEXT

Setting
(ie, Family Practice Residency Program - Community Hospital)

Level of Participants
(ie, 2nd year residents)

Contact Time
(ie, approximately 3 hours)

How Tied into Overall Curriculum
(ie, Generally worked into behavioral science blocks, rotations)

Scope of Substance Covered
(i.e. primarily alcohol, or both alcohol and other drugs, or primarily other drugs only)

RATIONALE

(This section is open-ended. This is the one place where there is no structure imposed, so use this space as you wish.)

OBJECTIVES

(Please try to list by number according to the categories below. Even if your component does not have objectives in all three areas, list whether they are knowledge, skill, or attitude objectives.)

Knowledge
1.
2.

Skills
1.
2.

Attitudes
1.
2.

INSTRUCTIONAL STRATEGIES AND ACTIVITY SEQUENCE

(To the extent possible, use a left-right page-break format as below with *Time* being the major dimension for the left-hand column.)

(Below are Examples of Time Dimensions)

Week 1 Week 2	(In the right-hand column are the activities which correspond to the time at the left)

or

Day 1
Day 2
Day 3

or

Session 1
10 Min.
30 Min.

or

Week 1
Day 1
Day 2

Week 2
Day 1
Day 2

or any combination of the above as it fits into your component.

(Some of you may find that this format works for only a part of this section. Try to use this for at least part because it greatly enhances the value of your write-up as a tool for a potential instructor attempting to replicate your component. It also forces you to try to be brief. Remember, additional information you wish to report on here can be included in the Supplemental Report.)

INSTRUCTIONAL MATERIALS AND RESOURCES

Readings: (List full references)

1.
2.

Audiovisual Aids: (If you aren't using any, write in NONE, otherwise list full sources as much as possible so the reader will know how to get copies.)

1.
2.

Materials Developed Specifically for This Component: (Write in NONE or list any manual titles, syllabus titles, handout titles etc. If the material is appended, please indicate by "See Appendix #." An example is below.)

1. (ie, Syllabus: "Diagnosing and Treating Substance Abuse." See Appendix 1.)

Faculty/Instructors: (List the specialty background and the number of faculty needed to teach each component.)

1. (ie, Family Physician Faculty: 2)
2.

Other Necessary Materials and/or Resources. (List whatever applies, or write in NONE. Examples here are computers, video playback monitors, simulated patients, and computer software.)

1.
2.

EVALUATION STRATEGIES AND INSTRUMENTS

(If possible, break up this section into a list of "strategies" and "instruments." If it works better for you to combine the two, then list by number without the separate headings below.)

Strategies:

1.
2.

APPENDIX C

Willingway Hospital
311 Jones Mill Rd.
Statesboro, GA 30458
Contact Person: Al J. Mooney, III, MD, Medical Director
(912) 764-6236

Willingway Hospital, a private 40-bed hospital, specializes in the treatment of alcoholism and drug dependency. The philosophy and concepts of alcoholism and other related chemical dependency conditions which underlie the treatment, environment, and relationships which patients experience at Willingway Hospital have been developed over a period of time. As a result of study as well as empirical evidence, certain factors have become basic concepts in the therapeutic rationale. The Willingway treatment program is based on the following four concepts:

1) The total cause of alcoholism and other related drug dependencies is unknown.
2) Alcoholism is at least in part a chemical illness.
3) There is a relationship between alcoholism and addiction to other drugs.
4) Alcoholism is a disease which affects the total person.

Willingway Hospital has begun to experience the rewards of having family physicians treating alcoholism as a primary disease for over 25 years. In the community, family physicians provide the most up-to-date treatment of alcoholism, along with a strong Alcoholics Anonymous group and alcoholism treatment network.

Residents from the University of North Carolina School of Medicine, Medical College of Georgia, Eisenhower Medical Center, Mercer University School of Medicine, and University of Florida College of Medicine rotating through Willingway Hospital appreciate the enthusiasm in the community. All have a chance to attend Alcoholics Anonymous and Al-Anon meetings, many for the first time. Being with patients in treatment and talking to recovering alcoholics (many of whom are staff members at Willingway Hospital) leave optimistic impressions of a disease appropriately treated — a family medicine illness treated by family physicians in a specialized and supportive setting.

A fellowship program in its third year at Willingway Hospital affords a one-year specialization program for family physicians with an interest in treating patients with alcohol and other drug addictions. Participants in the fellowship program study and practice the knowledge and skills necessary to treat alcoholics and drug addicts, and consult with other physicians who are managing such patients.

Substance Abuse Curriculum Development in Family Medicine

PART II:

TEN CURRICULUM EXAMPLES IN SUBSTANCE ABUSE

SUMMARY OF CURRICULUM EXAMPLES

AUTHOR	EDUCATIONAL LEVEL	HOW TIED INTO OVERALL CURRICULUM	MAJOR TOPICS
Funke	Predoctoral: 2nd Year	Module in Introduction to Clinical Medicine	Diagnosis, Attitudes
Brown	Predoctoral: 3rd Year	Computer-Assisted Instruction Module in Required Rotation	Diagnosis, Attitudes
Flynn	Residency: R1 - R2	Conferences and Individual Activities Integrated into Weekly Teaching and Behavioral Science Block Rotation	Diagnosis, Intervention, Attitudes
Goodman	Residency: R1	Module in Stress Reduction Rotation	Health Professional Impairment, Attitudes
Seale	Residency: R1	Part-Time Rotation in One-Month Community Health Rotation	Diagnosis, Intervention, Attitudes
Campbell	Residency: R1	One-Week, Packaged Flexible Module	Diagnosis, Intervention, Attitudes
Finch	Faculty	Independent Seminar Series and Individual Activities	Diagnosis, Intervention, Attitudes, Physician Impairment
Kuzel	Faculty	Independent Voluntary Module	Diagnosis, Intervention, Attitudes
Schulz	All	Seminar in a CME Course, Residency, or Medical Student Seminar Series	Intervention, Attitudes
Fleming	All (including nurses)	Implementation of Medical Management Protocol and Several Seminar Series	Withdrawal Treatment

PRACTICAL ADVICE ON TOUGH CURRICULUM ISSUES

Organizational Constraints

Virtually anyone wishing to introduce substance abuse curriculum into an already overflowing medical training curriculum is bound to encounter organizational constraints. Most of the STFM program participants met some institutional stumbling blocks. Educators are too often frustrated by such barriers.

Many of these barriers are common across institutions and residency training programs. Therefore, the curriculum example descriptions in Part II of this manual provide practical illustrations of solutions to common problems.

Curriculum Time and Prevailing Attitudes

The most commonly cited organizational constraint is shortage of curriculum time, a problem frequently stemming from prevailing negative attitudes of the faculty. This is not a new problem. Neither is it unique to substance abuse.

A solution can sometimes be found through creative and innovative ways in which to use or modify existing curriculum time. In the previous Summary of Ten Curriculum Examples, one can see how substance abuse teaching is, in many cases, incorporated into pre-existing curricular offerings. When integrated in this fashion, the result is a complementary addition to the overall curriculum, not merely the introduction of an isolated substance abuse teaching unit. This is one positive step in turning the tide of prevailing negative attitudes.

Several curriculum examples provide specific suggestions for encouraging faculty to make time available (Funke, Seale, Flynn, Kuzel, Finch, Schulz). One example (Funke) illustrates the innocuous introduction of faculty development activities as a necessary first step to implementing a curriculum component.

Four of the curriculum examples described are, by nature, not as demanding of faculty. One relies on computer- assisted instruction, thereby lessening faculty time and formal curriculum time necessary (Brown); another provides a specific, clinically relevant medical management tool useful to faculty of several specialties (Fleming); a third is incorporated into a stress reduction rotation where the topic of substance abuse is clearly relevant (Goodman); and a fourth is a packaged module with enough flexibility to be completed at any time in any setting (Campbell).

Instructional Strategies

Numerous instructional strategies are included in the ten curriculum examples. Each one has a section specifically devoted to the instructional strategies used and how they are implemented. Most of them include seminars or conferences designed to fit a larger module or series, but many can be free-standing.

Individual Activities

Most of the curriculum examples incorporate individual activities tied directly to other group instruction. Clinical application and/or observation in a general medical setting (Brown, Flynn, Finch, Fleming) or in a substance abuse treatment setting (Flynn, Seale, Campbell, Finch) are incorporated into several. Other, less intensive community treatment center site visits and guided attendance at self-help group meetings are used as well (Flynn, Seale, Finch). Self-instructional materials are important components of several examples (Brown, Flynn, Kuzel, Finch, Campbell), as are other specific self-directed exercises (Funke, Finch, Goodman).

Use of Experiential, Self-Disclosing Teaching Strategies

Experiential and self-disclosing strategies have been piloted in these curriculum examples with remarkable success. Role play is used in several examples (Funke, Brown, Flynn, Goodman, Campbell, Finch and Schulz), many of which include actual case vignettes in the appendices.

Simulated patients have also been used in creative ways. One example demonstrates how the involvement of other faculty in training a simulated patient for role play can be a useful faculty development exercise (Funke). Two others demonstrate how to use videotapes of interviews with simulated patients in an instructive, non-threatening manner with either faculty (Kuzel) or residents (Seale).

Use of Community Treatment Resources

Community treatment resources are used on several different levels in teaching. Examples are rotations at a residential treatment center (Seale); site visits to treatment centers and accompanied attendance at self-help group meetings (Flynn, Campbell, Finch); and bringing outside community treatment expertise into a family practice clinical setting (Flynn), or into the classroom as with the use of a recovering physician (Goodman).

Evaluation

Each curriculum example describes evaluation strategies. They include several different levels of evaluation, assessing both the performance of the learners and the effectiveness or reception of the teaching.

Evaluation of the Learners

Knowledge tests used include: modified essay and case management questions (Finch); objective pre- post-tests (Fleming, Goodman); and pre- and post-tests to assess attitude change (Goodman and Seale). Skills and behaviors are evaluated through a variety of different methods: chart reviews and other clinic documentation procedures to examine diagnostic and referral behaviors (Seale, Campbell, Finch); observation by faculty (Funke); and, medical record audits to document if and how a particular treatment protocol is being used (Fleming).

Other strategies to evaluate the learners include the use of simulated patients (Seale, Kuzel), written performance on clinical evaluations (Brown), process evaluations (Funke), self-reporting of stress reduction strategies (Goodman), and self-assessment of confidence in one's own knowledge andkills (Finch, Schulz).

Evaluation of the Teaching and Curriculum

All examples include some evaluation of the teaching itself or of the larger curriculum in which the example is included. Most do this through written evaluations and rating systems. Two compare learners exposed to the teaching/curriculum with those not exposed (Brown, Fleming).

Robert H. Funke, MD

Promoting Medical Student Recognition of Chemical Dependency

CONTENTS

Page

Curriculum Example Description 22

Appendices:

Case Presentation 23

Discussion Guide 24

Role Playing 25

Robert H. Funke, MD
Kingsport Family Practice Center
201 Cassel Drive
Kingsport, Tenn. 37660
(615) 246-6202

PROMOTING MEDICAL STUDENT RECOGNITION OF CHEMICAL DEPENDENCY

Context: This component is presented to second-year medical students as a module of an Introduction to Clinical Medicine course. A case of occult alcoholism is presented and discussed in a small group format during a single two-hour session.

Rationale: Medical students' attitudes toward chemical dependency begin to change negatively at an early point in their medical education. This module confronts such attitudes and promotes skills facilitating diagnosis as they begin actual patient contact in the general curriculum.

Objectives:

Attitudes

Generally, to describe ways in which one's beliefs can positively or negatively affect the diagnosis or treatment of substance abuse. Specifically:

1. To recognize the ethical conflict of avoidance (neglect) as opposed to coercion of a resistant abuser.
2. To demonstrate the hazards of stereotypic beliefs.
3. Chronic disease aspects--treatment failures, remission vs. cure, experience with end-stage illness.
4. Ambivalence due to personal or family use/abuse.

Knowledge

1. To state the prevalence of alcoholism in the general population and selected populations.
2. To state a definition of substance abuse and be aware of criteria for diagnosis.
3. To list common signs, symptoms, laboratory findings, and clinical presentations associated with alcoholism.
4. To describe success rates of substance abuse treatment.
5. To list risk factors for alcoholism.

Skills

1. To demonstrate basic technique and content of a substance abuse history from a patient or family.
2. To administer a CAGE questionnaire.
3. To be able to stage the degree of chemical dependency.

Instructional Strategies

The development of faculty instructors to lead the groups must naturally precede the student session. An instructor:student ratio greater than 1:10 is required for this component. The following sequence of faculty development activities is suggested.

1st Meeting Instructors discuss goals & objectives and contract individually or as a group for the accomplishment of the following tasks:

1. Preparation of an "unknown" case containing several clues of alcohol abuse.
2. Training of simulated patients to be interviewed by students for skill objectives.
3. Preparation of a discussion guide to foster some uniformity of content among the groups.
4. Recommend a reading list.
5. Create evaluation instruments, eg, exam questions and skills checklists.

2nd Meeting Instructors and simulated patients review objectives, activity sequence, evaluation strategy and methods, and rehearse actual role playing.

Students in the Introduction to Clinical Medicine course will have two hours of actual contact time with faculty in this module. The activity sequence is as follows:

ICM Orientation Assign required reading.

One week prior to module Students receive the written case with instructions to:

1. Generate problem lists with differential diagnoses.
2. State what additional clinical data would be needed to confirm their hypotheses.

Module Activities

20 min.	Group reviews the case and generates differential diagnoses.
20 min.	Instructor gives the students additional laboratory and physical examination data as requested. Then assists the "planning" of the role play.
40 min.	Role playing with simulated patients.
40 min.	Lecture and discussion of prevalence, common presentations, treatment outcome, and the importance of physician attitudes.

Instructional Materials and Resources

Readings:

1. "Finding Substance Abusers" in *Family Medicine Curriculum Guide to Substance Abuse*, STFM, 1984.
2. *Chemical Dependency* by Macaran Baird, M.D.
3. Hays JT, Spickard WA. Alcoholism: Early Diagnosis and Intervention. *J Gen Int Med* 1987; 2:420-427.
4. Alcoholism chapter in Taylor's *Family Medicine: Principles and Practice* or in Barker's *Principles of Ambulatory Medicine* text

Audiovisual Aids: None

Materials Developed for this Component:
Case presentation, discussion guide, and role-playing guide. See appendices.

Faculty: One family physician for every 8-9 students in the course.

Other Resources: One simulated patient in same number as faculty.

Evaluation

Faculty:

1. Process evaluation, including completion of tasks and observation for "multiplier effect."
2. Performance evaluation by students.
3. Self-reporting.

Students:

1. Knowledge objectives: Performance on written final examination.
2. Skill objectives: Observation and report by faculty and simulated patients.
3. Attitude objectives: Observation by faculty instructors.

Organizational Constraints

The principle constraint with the small group format teaching is its labor-intensive nature. This can be overcome by using volunteer faculty, although preparatory meeting times then become more difficult to arrange.

Hints to the Instructor

The development of a component de novo, as outlined for the first instructors' meeting, is a useful faculty development activity. However, unless the faculty is quite skilled at role playing (and interviewing substance abusers), the activities of the second meeting may be more important to the success of the module. Materials in the appendices might obviate the need for the initial meeting.

APPENDIX A

CASE PRESENTATION

MP is a 42 y.o. white female referred by a local gynecologist for an elevated blood pressure of 162/104. She reports that she has been meaning to see a physician for a "stomach problem" for several months, but put off an appointment until her elevated BP was discovered. She has had some borderline elevation for the past two years, whereas previously all readings were normal. She denies headache, dyspnea, orthopnea, chest pain, or known history of renal disease, or family history of hypertension. She reports frequent symptoms of nervousness, usually controlled by alprazolam, but occasionally intense, with flushed face, tremulousness, and palpitations. She takes no other medications, including OTCs.

In addition, she has had frequent epigastric discomfort, occasionally radiating to the back. It is sometimes relieved by food and perhaps aggravated by fatty foods. She reports a decreased appetite but no weight loss, occasional diarrhea, and two episodes of vomiting in the past two months. An UGI series in the past was interpreted as possible gastritis.

PMH. G2P2 S/P BTL. No other medical/surgical history.

Social History: She has been married 20 years to an attorney. She owns and manages a successful travel agency and travels frequently. She went to Mexico two months ago where she ate shellfish. She reports smoking 1/2 pack per day and drinking "socially." Her older daughter is in an Ivy League college, but her son is a high school student whom she describes as an "underachiever."

ROS: Remarkable for night sweats, insomnia, occasional feelings of guilt, and sexual dysfunction.

Exam reveals an attractive, neatly groomed white female.
Ht: 5'7" Wt: 138# P: 100 R: 16 T: 99 BP: 146/94.
Skin: Tan, no lesions. HEENT: Mild arteriolar narrowing.
Cardiovascular: BP 146/94 sitting and supine in all extremities, no murmurs, rubs, or gallops. Abdomen: Mild epigastric & RUQ tenderness; liver palpable on deep inspiration with normal span to percussion. Neurologic: Normal exam but with 2¢ to 3¢ DTRs, Babinski negative.

Available laboratory data: Hct: 38%, MCV: 99(80-94), Platelets: 110,000 (N = 150-450K); WBC 8,500 with 58 segs 6 bands 34 lymphs 2 eos. Urinalysis was unremarkable; Pap smear class I (normal). Multichannel chemistry screen: Na 138, K 3.8, Cl 101, HCO3 24, BUN 12, Glucose 72, uric acid 8.0 (2.3-7.7), LDH 274 (140-260), T. Bili 0.8, SGOT 58 (10-50), SGPT 40 (55), Alk Phos 100 (30-140), GGTR Gamma glutamyl transpeptidase 93 (5-55).

APPENDIX B

DISCUSSION GUIDE

1. **Generate a problem list of major concerns regarding this patient. Generate differential diagnosis for each of these problems.**

(The following are suggestions, not exhaustive lists.)

Labile hypertension:	Essential Secondary--Renal; endocrine; *Drug*; other "White coat hypertension"
GI symptoms	Gastritis Hepatitis Cholelithiasis Irritable Bowel Syndrome Infestation (travel)
Psychiatric symptoms:	Depression Panic or Anxiety Disorder Adjustment Disorder Organic Pheochromocytoma Hyperthyroidism SLE Porphyria Drug (Dependency)
Other:	Mild laboratory abnormalities; family problem (with son?)

CONSIDERING THE PRINCIPLE OF PARSIMONY OF DIAGNOSIS, IS THERE A SINGLE DIAGNOSIS OR ETIOLOGY FOR THESE PROBLEMS? CAN YOU MAKE A DIAGNOSIS NOW? (NO)

2. **You must close this encounter now. What tests and instructions would be useful regarding her next appointment? What additional information will you want from history or physical examination then?**

Return within a week. Bring spouse if possible.
Tests: Repeat CBC (unchanged), Plts (130K), multichannel chemistry (all WNL except GGT 102), T4 9ug/dl (5-12)
Additional tests: Any other lab or x-ray requested is normal except a drug screen positive for benzodiazepines.

Exam: BP 152/98; P 106; Remainder of exam unchanged.

[Generate a list of questions to be asked in a role play.]

From DSM III-R, to confirm or rule out. .

Major depression: She has sleep disturbance and guilt,three more symptoms required, one of which must be either depressed mood or significant loss of pleasure.

Panic disorder: Attacks must be precipitated by situations, and must not be secondary to an organic condition. (eg, withdrawal.)

Generalized anxiety disorder: Must be present six months, more than 50% of days. Excessive worry about two life circumstances, and describe at least six of the 18 anxiety symptoms in DSM III-R.

Alcoholism: Screen with the CAGE Questions.

Have you ever felt the need to CUT DOWN on your drinking? Have you ever felt ANNOYED by criticism of your drinking? Have you ever had GUILTY feelings about drinking? Do you ever take a morning EYE OPENER?

Most alcoholics will answer yes to two questions (sensitivity 90%), but only half of those answering yes to two are alcoholic (positive predictive value 50%) in the general practice setting.

Diagnostic criteria for substance abuse: Use despite a medical or social problem; use in risky situations. Continuous use for one month, or repeated problem use.
Dependency: Using more than intended; feeling a need to cut down; preoccupation leading to loss of other activities; increased tolerance by 50%; occurrence of withdrawal symptoms.
Other pertinent history: Blackouts? Last drink? Other drugs? Family history? Pattern of use?

[Go to role play.]

What is the diagnosis? Alcoholism with 2ô gastritis, hypertension (it is estimated that up to 20% of "essential hypertension" is due to alcohol), thrombocytopenia, and neuroadaptation (physical dependency).

Are there any clues in the case which cannot be due to alcohol? (NO)

3. **How common is alcoholism in the community? In a general medical practice? On a med/surg floor in the hospital? A trauma service?**

7% of the general public. 10% of ambulatory practice. 20% of general inpatients. Up to 50% of trauma patients. Age, gender, ethnicity, and environment all affect these numbers.

4. **What are common ways for alcoholism to present?**

Complaints: Hypertension; insomnia; GI symptoms-gastritis or diarrhea; fatigue; sexual dysfunction; accidents; first seizure in an adult; Monday morning illness; anxiety or request for tranquilizers.

Exam: Unreliable, most are late findings or signs of withdrawal.

Lab: GGT Most sensitive test (50%). Microsomal enzyme induction.

Increased: SGOT; Alk phos; MCV-due to folate deficiency or hemolysis; triglycerides; uric acid--due to increased lactic acid from metabolism of alcohol.
Decreased: platelets; Mg++; glucose.

5. **What are the success rates with treatment?**

If success is defined as abstinence for two years, then good programs are reporting rates of 60%. This is by nature a chronic, relapsing disease, and relapse usually occurs within the first six months. A relapse should not necessarily be considered a treatment failure. In fact, skillful physicians or counselors will use a relapse to strengthen the recovery plan with a goal of ever longer remissions and fewer and shorter relapses.

The earlier the diagnosis, the greater the chance of recovery. It is only the end-stage alcoholic who has lost the resources of job, family, and health that presents the lowest rate of recovery. Fewer than 5% of all alcoholics are of the "skid row" type.

6. **Attitudes**

Discuss the ethics of avoidance (neglect) of self- destructive behavior as opposed to coercion of a resistant addict.

Discuss possible attitudinal obstacles to diagnosis:

Stereotypic beliefs—This case was designed to confront the "derelict male with weak will" stereotype.
Frustration from a past experience.
Others.

Define "enabling." Was the prescribing of tranquilizers for this patient a form of enabling?

APPENDIX C

ROLE PLAYING

Questions not related to alcohol have been unproductive up to now. There are three types of patient roles: resistant, compliant, and ambivalent.

CAGE QUESTIONS:

C- I quit for two weeks last summer while we were on vacation, and it was no problem. (+)

A- Why are you asking me this?! Do you think I am an alcoholic?! (+)

G- Yes, I was a little embarrassed after our office Christmas party; I didn't remember it very well. (+) [Blackout, too]

E- I might have a Bloody Mary at a brunch, otherwise I never drink before noon. (-?) ["Control ritual" may indicate loss of control.]

Family history: Mother has recurrent depression, Valium dependency.

How much?	Wine with dinner, maybe a glass at bedtime. Otherwise only socially.
2nd How much?	We buy 2-3 cases of wine per month, but my husband drinks some too, and we entertain a lot.
Social events?	Two parties most weekends; promotional events for work on 1-2 nights per week.
Last drink?	Last night. Other drugs? Just Xanax, as prescribed.

Richard L. Brown, MD, MPH

Improving Early Diagnosis of Substance Abuse by Medical Students

CONTENTS

Page
Curriculum Example Description 29

Appendices:

Handout for Conference 2: 32
Scheme for Physician Treatment of Substance Abuse

Richard L. Brown, MD, MPH
Department of Family Medicine
Jefferson Medical College
1015 Walnut Street, Suite 401
Philadelphia, Pennsylvania 19107
(215) 928-8363

IMPROVING EARLY DIAGNOSIS OF SUBSTANCE ABUSE BY MEDICAL STUDENTS

CONTEXT

Setting

Six-week required rotation in family medicine

Level of Participants

Third-year medical students (eight to 10 students)

Contact Time

Two hours plus after-hours computer and clinical assignments

How Tied into Overall Curriculum

Worked into conference schedule plus after-hours assignments

Scope of Substances Covered

Alcohol and other drugs

RATIONALE

The overall goal for the curriculum is for students to acquire basic knowledge, skills, and attitudes to enable and empower them to diagnose substance abuse in its early stages. Assumptions made in developing this curriculum were that:

1. All physicians should be able to identify substance abuse at an early stage.
2. In order to motivate physicians to learn to do so, they must perceive that this skill will have utility, that is, that they will be able to initiate successful treatment.
3. Medical students should be taught about clinical aspects of substance abuse while they are learning clinical aspects of other medical topics.
4. Curricular time and faculty expertise for teaching about substance abuse is scarce.
5. Traditional teaching methods, such as lectures, efficiently convey information to students but are less successful than independent learning methods in promoting long-term knowledge retention, application of new knowledge to clinical situations, improvement in clinical problem-solving, changes in attitude, and motivation for further learning.
6. Integrating independent learning activities into a curriculum on substance abuse can optimize use of faculty and curricular time, and can promote greater retention and application of knowledge and skills, changes in attitude, and motivation for further learning.

In view of these assumptions, it was decided to produce computer-assisted instruction (CAI) modules to convey basic facts to students, allowing conference time for discussion of more difficult concepts, attitudinal issues, and complex skills. In addition, it seemed desirable to provide students with real clinical experience in applying their newly learned knowledge and skills and examining their attitudes.

OBJECTIVES

Knowledge

1. To define substance abuse
2. To state the prevalence of substance abuse in the general population and in patient populations in various medical care settings
3. To state who is at risk for substance abuse
4. To discuss the impact of substance abuse on individuals, their families, and society
5. To list the signs and symptoms of an early substance abuse problem
6. To discuss the chronic, relapsing, and remitting nature of substance abuse disorders
7. To cite success rates of substance abuse treatment

Skills

1. To take a sensitive substance abuse history
2. To perform a physical examination directed toward recognizing substance abuse
3. To administer the MAST and CAGE questionnaires and interpret the results
4. To utilize common laboratory studies in assessing patients for substance abuse
5. To recite the important ingredients of successful confrontation

Attitudes

1. To describe attitudes which facilitate physicians in diagnosing and treating substance abuse problems
2. To describe how their personal attitudes regarding substance abuse may help or hinder them in diagnosing and treating substance abuse

INSTRUCTIONAL STRATEGIES AND ACTIVITY SEQUENCE

CAI Module 1	Students perform a clinical evaluation of a patient who has recurrent epigastric pain and desires a refill of his cimetidine. By selecting from menus which list available data in the areas of history, physical examination, diagnostic tests, and past records, students are asked to gather sufficient information to construct a complete management plan for the patient. Correct diagnoses are alcoholic gastritis, peptic ulcer disease, hypertension, and alcoholism. On completing the exercise, students receive immediate feedback on their diagnoses and the number of

clues to substance abuse they uncovered. The program summarizes for each student the common symptoms and signs with which early substance abuse can present.

Syllabus After the students complete CAI Module 1, they receive a syllabus which introduces them to the substance abuse curriculum, outlines it educational goals and objectives, summarizes its requirements, and describes the clinical assignment and the criteria for student grading.

CAI Module 2 Students take a computerized version of Chappel and Veach's Substance Abuse Attitude Survey (SAAS) and receive their scores and their interpretations. The computer program informs the students how their attitudes may help or hinder their effectiveness in diagnosing and treating substance abuse.

CAI Module 3 Students take computerized versions of the MAST and the CAGE questionnaires twice--once for themselves and again as a family member or friend who may have a substance abuse problem. The computer calculates the scores, gives the interpretation, and teaches the students how to do the same. Finally, with attention to the instruments' sensitivity, specificity, and positive predictive value, it demonstrates how physicians can use the MAST and CAGE questionnaires in clinical practice.

Conference 1 At the end of the second week of the rotation, after each student has completed the above activities, the group attends a didactic and discussion session, which covers: (a) the effects of substance abuse on individuals, families, and society, including data on prevalence, mortality, and morbidity; (b) failure of most physicians to recognize and treat substance abuse; (c) barriers to physician recognition and treatment; (d) definitions of substance abuse; (e) attitudes, with emphasis on the disease concept, physician anger and frustration in caring for substance abusers, and patient blame and responsibility; (f) substance abuse as a chronic, relapsing, and remitting disease; (g) risk factors for substance abuse; (h) a review of signs and symptoms of early substance abuse and use of the MAST and CAGE; (g) approach to taking a sensitive substance abuse history; and, (h) approach to finding physical and laboratory evidence of substance abuse.

Conference 2 During the third week of the rotation, a second conference focuses on the potential role for nonpsychiatric physicians to treat substance abuse. Data on treatment efficacy are presented, and early identification, engagement in treatment, and follow-up are emphasized. Most of the time is spent on a role play in which a student plays a substance abuser and the instructor plays his or her physician. The instructor stops the interview periodically to elicit discussion from the observing students on how they would proceed as the physician. Also, the instructor stops to describe the techniques used. During the conference, students refer to a hand-out that summarizes proper interviewing and counseling techniques.

Clinical Assignment During the final three weeks of the rotation, students identify a patient who is at risk for substance abuse; perform an appropriate history, physical examination, laboratory evaluation, and chart review, as is feasible; and hand in a three-page write-up of their evaluation. The write-up includes subjective data; objective data; assessment of the likelihood of substance abuse, including evidence for and against the diagnosis; a plan as if the student were the patient's primary physician; an assessment of the student's strengths and areas for improvement in interviews; and, a description of what the student learned from the assignment. The instructor provides written comments on each write-up.

INSTRUCTIONAL MATERIALS AND RESOURCES

Readings

1. West LJ, Maxwell DS, Noble EP, Solomon DH: Alcoholism. *Annals Int Med* 1984;100:405-416.
2. Skinner HA, Holt S: Early intervention for alcohol problems. *J R Col Gen Pract* 1983;33:787-791.
3. Nicholi AM: The nontherapeutic use of psychoactive drugs. *New Engl J Med* 1983;308:925-932.

Materials Developed Specifically for This Component

1. Three computer-assisted instruction modules, described above
2. Syllabus, described above
3. Handout: "Scheme for Physician Treatment of Substance Abuse," distributed at Conference 2 (see Appendix)

Faculty/Instructors

A family physician can effectively administer this curriculum alone. However, it is helpful to have present at conferences a substance abuse treatment specialist who emphasizes the importance of the role of nonpsychiatric physicians identifying and treating substance abuse.

Other Necessary Materials and/or Resources

Student access to an IBM PC-compatible microcomputer with 512k and color graphics is essential.

EVALUATION STRATEGIES AND INSTRUMENTS

Strategies

1. Evaluation of students is based on their:
   a. Completion of the independent learning tasks in a timely fashion. On completing each CAI module and returning the diskette, each student signs a log sheet including the date on which the module was completed.
   b. Write-ups of their clinical evaluation.
   c. Performance on questions that assess their knowledge of substance abuse which might appear on their final examinations.
2. Evaluation of the curriculum is based on:
   a. The students' performance as outlined above. Their performance on questions that assessed their knowledge at the end of the rotation (N = 33) was compared to that of students who took their family medicine rotations at different sites where they were not exposed to this curriculum (N = 75). Students exposed to the curriculum more frequently identified alcoholism as the most likely

cause of a symptom complex of abdominal pain, difficulty sleeping, marital problem, and poor performance at work (P.002); recalled at least three CAGE questions (P.001); recalled the name of a written screening questionnaire for alcoholism (P.001); and correctly named the two most sensitive laboratory screening tests for alcohol abuse(P.001). However, in deciding whether an intermittent cocaine and marijuana user had a substance abuse problem, both groups of students used with the same low frequency a definition of substance abuse based on the effects of the patient's drug use.

b. Student ratings of the CAI modules. They rated the modules on 7-point Likert scales whose end points were Extremely Familiar (1) and Extremely New (7), Extremely Unimportant and Extremely Important, Extremely Useless and Extremely Useful, Extremely Unrealistic and Extremely Realistic (for the case in Module 1 only), Extremely Uninteresting and Extremely Interesting, Extremely Unenjoyable and Extremely Enjoyable, Extremely Uneducational and Extremely Educational, and Extremely Not Worthwhile and Extremely Worthwhile. Means for Familiarity/Newness for the three modules were 3.2, 3.9, and 4.9, respectively. Means for all other responses for all three modules ranged from 5.3 to 6.4.

c. Student ratings of the conferences. Thirty-three students evaluated Conference 1. Only 18 students evaluated Conference 2, whose format was changed based on previous student evaluation data. Students evaluated the conferences on appropriateness of content to student level, amount learned, instructors' command of the subject, clarity and organization, instructors' enthusiasm, responsiveness to students' questions and reactions, and instructors' overall effectiveness. A 6-point scale was used: very poor (1), poor, fair, good, very good, and excellent (6). Means of all ratings ranged from 4.7 to 5.6.

d. Summary student ratings. An end-of-rotation questionnaire polled exposed and unexposed students on the substance abuse teaching on their rotation. On a 6-point, very poor to excellent scale, as described above, the mean of the quality of substance abuse teaching for the 33 exposed students was 5.2; for the 48 of 75 unexposed students who did not check Not Applicable, the mean was 3.6 (P

Instruments

1. Evaluation forms for the CAI modules
2. Evaluation forms for the conferences
3. End-of-rotation questionnaire

ORGANIZATIONAL CONSTRAINTS

Constraints	**Suggestions to Overcome**
1. Student access to computer	1. Use a computer or learning resource center if available.
2. Gaining faculty permission	2. Emphasize that students for students to evaluate are not required to their patients for perform all potential substance abuse aspects of the evaluation, and that they are not to attempt to initiate treatment.

HINTS AND NOTES TO THE INSTRUCTOR

1. In order for CAI Module 1 to be most effective, students should not know in advance that the topic of the computer modules is substance abuse.
2. In order to facilitate discussion of students' attitudes about substance abuse during Conference 1, it is important to create a conducive atmosphere. A small room with a blackboard and chairs around a table seems best. Self-disclosure by an instructor can help set an intimate tone. A non-judgmental stance about attitudes by the instructors is crucial. Attitudes should not be judged to be bad or good, but simply determined by one's culture, family, and previous experiences. However, it can be explained that some attitudes can be maladaptive for physicians who wish to help patients with substance abuse, and it is useful to explore where these attitudes may come from and how they MAY not be well-founded. Often some students are comfortable discussing their own scores on the SAAS. One way to initiate conversation on this is to inform students in advance that nobody will be forced to talk about their attitudes. Then state that many students are surprised by their scores and ask if this happened to anyone here. It is particularly instructive to engage students in a conversation about the potential disparity between their expressed conviction that substance abuse is a disease and their admission that they do find themselves acting to the detriment of patients' best interest in response to their anger about patients' behavioral expression of the disease.
3. It is important to emphasize to students the limits of the clinical assignment. Students are not required to uncover hidden substance abuse; they need only identify and evaluate patients at risk by virtue of a particular medical problem, family upheaval, anxious or depressed feelings, a laboratory result, etc. Also, if a student does uncover substance abuse, he or she is expected not to perform confrontation or initiate treatment, but only to alert his or her clinical supervisor.

REFERENCES

1. Chappel JN, Veach TL, Krug RS: The Substance Abuse Attitude Survey: An instrument for measuring attitudes. *J Stud Alc* 46:48-52,1985.
2. Ewing JA: Detecting alcoholism; the CAGE questionnaire. *JAMA* 252:1905-1907,1984.
3. Selzer ML, Vinokur A, van Rooijen L. A self-administered Short Michigan Alcoholism Screening Test (SMAST). *J Stud Alc* 36:117-126,1975.

APPENDIX

Handout for Conference 2

Scheme for Physician Treatment of Substance Abuse

- I. Overall goals and options
  - A. Patient accepts that he/she has a problem. If so, then:
    - 1. Patient engages in what physician believes is optimal treatment.
    - 2. Patient engages in some form of treatment.
    - 3. Patient will see a specialist who will determine what form of treatment is optimal.
    - 4. Patient agrees to a family meeting to initiate family treatment.
    - 5. Patient agrees to a follow-up visit.
    - 6. "Intervention."
  - B. If patient does not accept that he or she has a problem:
    - 1. Patient agrees to a trial of no substance use with follow-up.
    - 2. Patient agrees to a trial of controlled substance use with follow-up.
    - 3. Patient agrees to a family meeting to discuss his or her concerns about the patient's and family's well-being.
    - 4. Patient agrees to a follow-up visit.
    - 5. "Intervention."
- II. The basic steps
  - A. Establish a supportive relationship
    - 1. Use basic interview skills
      - a. Attending (attentiveness, nodding, eye contact)
      - b. Paraphrasing
      - c. Reflection of feeling
      - d. Summarizing
    - 2. Make statements of:
      - a. Empathy
      - b. Respect
      - c. Partnership
  - B. Move toward a mutual understanding of the impact of substance abuse on the patient's life.
    - 1. More advanced interview skills
      - a. Probing
      - b. Interpreting
      - c. Redirecting
      - d. Self-disclosing (de-emphasize for students)
      - e. Confrontation
    - 2. The message to convey
      - a. You have used substances to the point where you and, if applicable, others around you, have experienced negative consequences, such as (LIST).
      - b. You continue to use substances despite the deleterious effects, suggesting that, at least at times, you are unable to control your use.
      - c. Your inability to control your use is not your fault; it can be genetic, it may be a biochemical problem, and it may be a disease.
      - d. Like other medical conditions, substance abuse problems require treatment; although you may be able to control the problem temporarily, your chances of doing better in the long run are definitely improved by getting treatment.
      - e. I care about you, and I'd like to help you get help.
  - C. Negotiate the treatment plan
    - 1. Allow patient to express his or her own solutions, concerns, and fears.
    - 2. Acknowledge fears, allay concerns, explain your reservations about the patient's solutions, and make a recommendation for treatment.
    - 3. If necessary, make a reasonable compromise in the treatment plan to gain acceptance.
  - D. Contract with the patient
    - 1. Review details of the negotiated treatment plan.
    - 2. Obtain patient's agreement.
    - 3. If appropriate, make arrangements.
    - 4. Schedule follow-up appointment to review treatment.
- VI. Avoid:
  - A. Comparisons with other people ("I don't drink nearly as much as my friends do.").
  - B. Value-laden terms (alcoholism, alcoholic, drug addict, etc.).
  - C. Scare tactics and threats.
  - D. Arguments. "You know more about your life than I do, but I am an expert on substance abuse and how it affects people. Some of your impressions may be colored by unconscious denial. Nevertheless, we may agree to disagree, and I remain concerned about you and your use of substances."
  - E. Hostility and terminating the relationship. No matter what happens, remain available to the patient, and seek follow-up.
  - F. Enabling.

Sources: Unpublished materials from Project ADEPT, Brown University, Providence, Rhode Island, 1987; and National Center for Alcohol Education: Counseling Alcoholic Clients (DHEW Publication Number [ADM] 78-711). Arlington, Virginia: National Institute for Alcoholism and Alcohol Abuse, 1978

Stephen P. Flynn, MD

Alcoholism: Diagnosis and Intervention for Family Physicians

CONTENTS

Page
Curriculum Example Description 35
Appendices:
Handout for Conference Session 1: 37
Screening and Establishing the Diagnosis of Alcoholism
Handout for Conference Session 2: 43
Presenting the Diagnosis of Alcoholism and Working with Denial

Stephen P. Flynn, MD
Fairview General Hospital
18200 Lorain Ave.
Cleveland, Ohio 44111
(216) 476-7086

ALCOHOLISM: DIAGNOSIS AND INTERVENTION FOR FAMILY PHYSICIANS

CONTEXT

Setting

Family Practice Residency Program - Community Hospital

Level of Participants

First- and second-year family practice residents

Contact Time

Approximately 5-10 hours over a two-year period

How Tied into Overall Curriculum

This component is integrated into an overall three-year curriculum on substance abuse. This component consists of two hours of conference time included in the first or second year of residency during regularly scheduled weekly conferences. It also includes three to eight hours of activities during a one month behavioral science block rotation in the second year.

Scope of Substances Covered

Primarily alcohol

RATIONALE

Goal: The family practice residents will acquire the knowledge, skills and attitudes to diagnose alcoholism in their patient population and to intervene in such a way as to manage resistance and initiate appropriate treatment and referral of such patients, while maintaining a respectful, continuing relationship.

OBJECTIVES

Knowledge Objectives. The resident will be able to:

1. Describe the clinical signs and symptoms which would indicate the possibility of alcoholism in an individual or family member.
2. State questions used in screening for alcoholism, including the CAGE instrument.
3. Describe clinical criteria for establishing the diagnosis of alcoholism, using information from the history, physical and laboratory examinations.
4. Describe a method of presenting the diagnosis of alcoholism which would maintain respect and a continuing relationship with the patient.
5. State at least two methods for dealing with denial or resistance from the patient or family.
6. Discuss the role of other family members in the process of diagnosing and intervening with an alcoholic patient.
7. List at least two community resources which are available to assist in further assessment, intervention and treatment.

Skill Objectives: The resident will be able to:

1. Conduct a thorough alcohol use history, including screening questions and follow-up history, physical and laboratory examinations to establish the diagnosis of alcoholism.
2. Discuss the diagnosis of alcoholism with a patient.
3. Conduct a family interview to establish and discuss a diagnosis of alcoholism.
4. Initiate a referral for further assessment and treatment to a local community resource.
5. Participate in a formal intervention session under the supervision of a trained alcoholism professional.

Attitudes Objectives: The resident will be able to:

1. Display a respectful and non-judgmental manner in treating patients and families with alcoholism.

INSTRUCTIONAL STRATEGIES AND ACTIVITY SEQUENCE

1. The initial two hours of this curriculum component involve conference time. This can be done as one two-hour conference or, as below, two one-hour conferences.

Session 1	This one-hour conference is conducted by a family physician faculty member.
40 min	Didactic presentation of signs and symptoms of alcohol abuse, screening questions including the CAGE instrument, further history, physical and laboratory examinations to establish the diagnosis of alcoholism.
20 min	Self-administer the Short MAST and role play taking an alcohol history, including the CAGE questions.
Session 2	This one-hour conference is scheduled within one month of the above and is taught by the same faculty member.
30 min	Didactic presentation of methods of presenting the diagnosis and working with patient denial, including use of family members and community resources.
30 min	Role play of presenting diagnosis and working with denial. Residents divided in groups of two to four to increase participation. Facilitated by family physician, alcohol counselor, and, when available, recovering alcoholics.

2. Selected activities during a one-month behavioral science block rotation for second-year residents.

6-8 hrs.	Site visits to inpatient and outpatient alcohol treatment facilitities, in part to observe assessment process.
1-2 hrs.	Attendance at an open AA meeting, accompanied by a faculty member or community family physcian.
1 hour	Individual review of videotape series, "Alcoholism and the Physician."
1 hour	Participation in a formal intervention session with an adolescent patient in an inpatient treatment facility.

3. Assessing patients in the family practice center with an alcohol counselor.

As needed: The residency has an agreement with a local chemical dependency treatment facility to provide for an alcohol counselor to come to the family practice center as needed, on a pre-arranged basis, to meet with the resident and his/her patient to conduct an assessment for possible alcohol or other drug abuse problems. This process is initiated by the resident. This serves several purposes, including resident education, a "second opinion" for patients with denial, and facilitation of referral for treatment.

INSTRUCTIONAL MATERIALS AND RESOURCES

Readings

1. Milhorn HT. The diagnosis of alcoholism. *Am Fam Physician* 1988; 37:175-183.
2. Clark WD. The medical interview: focus on alcohol problems. *Hosp Pract* 1985 (Nov): 59-68.
3. Barnes HN, Aronson MD, Delbanco TL, eds. *Alcoholism: A guide for primary care physician*. Springer-Verlog, New York, 1987.
4. Clark WD. Alcoholism: Blocks to diagnosis and treatment. *Am J Med* 1981; 71:275-86.
5. National Council on Alcoholism. .Criteria for the diagnosis of alcoholism. *Ann Int Med* 1972; 77:249-258.
6. Weinberg JR. Interview techniques of diagnosing alcoholism. *Am Fam Physician* 1974; 9:107-15.
7. Baird MA. Chemical dependency: a protocol for involving the family. *Fam Sys Med*; 3:216-20.
8. "Primary care family counseling for chemical dependency" in Doherty WI and Baird MA. *Family Therapy and Family Medicine*. Guilford Press, NY; 1983; p 197-203.
9. Ewing JA. Detecting alcoholism: the CAGE Questionnaire. *JAMA* 1984; 252:1905-7.
10. Holt S, Skinner HA, Israel Y. Early identification of alcohol abuse: 2. Clinical and laboratory indications.

Can Med Assoc Assoc J. 1981; 124: 1279- 99.

Audiovisual Aids:

1. Alcoholism and the Physician Parts I-IV. (Attitudes, Early Diagnosis, Confirming the Diagnosis, and the Physician's Role); Hazelden Educational Materials; Box 176; Center City, MN 55012; 1-800-328-9000.

Materials Developed Specifically for This Component

1. Handout for conference session 1: Screening and Establishing the Diagnosis of Alcoholism (see Appendix A)
2. Handout for conference session 2: Presenting the Diagnosis of Alcoholism and Working with Denial (see Appendix B)

Faculty/Instructors:

1. Family physician faculty: One, with some interest and expertise in substance abuse. Faculty development activities are described for interested individuals in the Hints and Notes to Instructor section.

This faculty member would teach didactic conferences, facilitate role-playing, and accompany resident to AA meeting. These responsibilities could be rotated or shared with other family physician faculty or community preceptors. This component could be taught by nonphysician faculty, but an important role-model function and clinical credibility would be lost.

2. Alcohol counselor: One, available part time or on consultant basis.

This faculty member would assist in role playing, supervise on-site visits to alcohol treatment facilities, conduct assessments on substance abuse patients in the family practice center, and act as an educational and clinical resource for the residents and faculty.

Other Necessary Materials and/or Resources

1. An educational and clinical liaison with at least one local chemical dependency treatment facility.
2. (Optional) Alcoholic individuals, with at least 2 years of continuous sobriety and involvement in a recovery program, to participate in role-playing interviews with the residents.

EVALUATION STRATEGIES AND INSTRUMENTS

1. Evaluation of resident knowledge, skills, and attitudes:

   A. Written self-assessment form about knowledge and comfort in diagnosing alcoholism. This is administered at beginning of behavioral science block rotation in the second year to assist in planning activities for the month.

   B. Written evaluation of resident performance completed by the alcohol counselor at the end of the behavioral science rotation.

   C. Quick test for Professionals Understanding of Alcoholism administered during the behavioral science rotation.

   D. Written evaluations by preceptors of patient care in the office and hospital settings, which would include encounters with alcoholic patients on a random basis.

All written evaluations are kept in the resident's permanent file and are reviewed with the resident two to four times a year by the resident's faculty advisor.

2. Evaluation of the Curriculum and Instructors

   A. Residents complete written evaluations of the conference sessions, which are reviewed by the presenter.

   B. Residents complete a written evaluation of the behavioral science block rotation, including the substance abuse component, which is reviewed by the rotational coordinator.

   C. Residents participate in an annual evaluation of the overall residency curriculum, which is reviewed by the curriculum coordinator and residency faculty.

   D. Residents complete a semi-annual general written evaluation of all residency faculty members. A summary is provided to the individual facutly member by the residency director.

ORGANIZATIONAL CONSTRAINTS

Constraints	*Suggestions to Overcome*
1. Lack of family physician expertise in substance abuse	1. Individualized faculty development (see Hints to Instructor section)
2. Need for liaison with local alcohol treatment center	2. Personal visits to several sites. Treatment center personnel were eager to participate in resident education.
3. Time in the curriculum for conferences and rotational activities.	3. Negotiation with other faculty, emphasizing willingness and importance of teaching by family physician.

HINTS AND NOTES TO THE INSTRUCTOR

1. Individualized faculty development

The impact of having a family physician assume the leading role in teaching this curriculum was very positive on the residents and faculty. It provided clinical credibility and legitimized the family physician's role in this area. However, teaching about substance abuse is delegated entirely to non-family physician faculty in the majority of family practice residencies in this country. One of the reasons may be lack of comfort and expertise in teaching about substance abuse. The following list of resources would be helpful for individual faculty members to increase their knowledge and skills in this area:

A. Readings listed under instructional materials. The book *Alcoholism:A guide for the Primary Care Physician* edited by Barnes, Aronson, and Delbanco was especially helpful.

B. Three-day Faculty Development Workshop in Substance Abuse Education sponsored by the Society of General Internal Medicine. The faculty includes some of the authors of the monograph cited above. The workshops will be held periodically in different geographical locations over the next few years.

C. Review courses, regional and national meetings sponsored by the American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) and the Association for Medical Education and Research in Substance Abuse(AMERSA).

D. The Substance Abuse Working Group of the Society of Teachers of Family Medicine, which includes the fellows who participated in this faculty development project.

E. Free educational publications from the National Institute on Alcoholism and Alcohol Abuse (NIAAA) and National Institute on Drug Abuse (NIDA).

F. Visiting local alcohol treatment centers. These professionals are often enthusiastic about working with family physicians as potential referral sources.

G. Visiting a residency program with a substance abuse rotation and participating in the experience as a learner. One example is a one-week "immersion" experience at Willingway Hospital in Statesboro, Georgia. This excellent treatment facility is a family-run enterprise under the supervision of a family physician, Al Mooney, MD.

H. Attending local AA and Al-Anon meetings. Educational. Changes attitudes and creates enthusiasm to observe people in recovery process.

2. Teaching interview skills as involved in this curriculum component requires active resident participation. Didactic conferences are least successful and should be used only to introduce the material. Role playing with other residents, faculty, and recovering alcoholics was effective. Site visits and other experiential learning are also recommended. As previously discussed, personal visits to local treatment centers often resulted in a warm welcome and interest in participating in resident education. Contacts with recovering alcoholics can be made through these facilties or through attendance at AA meetings. If recovering alcoholics are used for teaching residents, they should have several years of continuous sobriety and be involved actively in a good recovery program, such as AA. Furthermore, these volunteers should be coached in their expected roles. If these guidelines are not followed, the potential exists for some angry and non-productive interactions to occur.

APPENDIX

A. Handout for conference session 1: Screening and Establishing the Diagnosis of Alcoholism.

B. Handout for conference session 2: Presenting the Diagnosis of Alcoholism and Working with Denial.

APPENDIX A

Conference #1

ALCOHOLISM: SCREENING AND ESTABLISHING THE DIAGNOSIS

I. Prevalence and Significance

- Alcohol dependence is the most commom medical and psychiatric problem in the U.S.
- 2/3 of the population drinks
- 1/10 of those who drink are alcoholics
- 1/4 of children grow up in homes affected by alcohol or other drug abuse
- 10%-15% of patients visiting a family physician are alcoholics
- Up to 25% of patients admitted to the hospital are alcoholics
- Direct cost for treatment of alcoholism in U.S. is 14.9 billion dollars annually
- Alcoholism, due to its relationship to cirrhosis, accidents and suicide, is the major cause of death in 20-40 year-old males

II. Definition and Diagnostic Criteria

Alcoholism is a chronic, and usually progressive, disease which is characterized by the continued use of alcohol in a manner which causes major life problems in any of the following areas: health and medical well-being, family and social relationships, occupational or school endeavors, or legal and financial responsibilities.

A problem drinker is a person who is experiencing a serious life problem as a result of his/her alcohol use.

An alcoholic is a "person who drinks, has problems, and continues to drink".

Alcoholism has more to do with the pattern of drinking, not just the amount.

There are formal and detailed criteria for diagnosing alcoholism as listed in DSM IIIR and the National Council on Alcoholism criteria (see references). These are helpful to illustrate different aspects of alcoholism but are too cumbersome for practical use. It is better to keep the above general definition in mind when making the diagnosis or referring a patient for treatment.

III. Clinical Clues to the Diagnosis

Symptoms and signs — see Table I

Lab — see Table II

Any of these findings during a patient visit suggest the possibility of alcohol or other drug abuse. A careful alcohol history, including screening questions may then be taken to investigate this possibility.

IV. Screening and Taking an Alcohol History

Screening for alcohol abuse is appropriate during:

- complete physicals and general check-ups
- hospital admissions (high incidence of alcoholism)
- chief complaint indicates possible alcohol abuse, including trauma
- family problems indicating possible alcohol abuse
- anytime

Part of social history when asking about personal habits. Start with less threatening topics, eg., exercise, coffee, cigarettes, alcohol, illegal drugs.

By routine, most inquire about frequency and amount of alcohol use, eg, "Do you drink?" "Do you use alcohol?" "Tell me about your use of alcohol." "How often do you drink?" How much would you usually drink at one time?"

The way the patient answers is as important as what is said. Alcoholics can be very vague, nonchalant, diverting and defensive. If patient denies drinking, ask, "Why not?"

Quantity is not as important as pattern of use, how alcohol affects patient and family.

The CAGE questions are useful for screening. They can be easily asked as part of the alcohol history. Any positive answer requires further follow-up. Two or more positive answers indicate a diagnosis of alcoholism until proven otherwise.

CAGE Questions:

C - Have you ever felt you ought to *Cut* down on your drinking?

A - Have you ever been *Annoyed* by people criticizing your drinking?

G - Have you ever felt *Guilty* feelings about your drinking?

E - Have you ever taken a morning *Eye*-opener drink?

The MAST (Michigan Alcoholism Screening Test) is also a good screening test, but is longer and not as practical. It can be self-administered. There is a short form (SMAST) (see the Milhorn article in references) which is fairly reliable and easier to use. Some use the MAST as a follow-up to confirm the diagnosis when the CAGE is positive.

MAST — (Michigan Alcoholism Screening Test)

The following two questions have shown a strong correlation to the MAST if both are answered positively:

1. When did you have your last drink? (positive = within last 24 hrs)
2. Do you think that you have a drinking problem? Have you had a problem in the past?

Taking a family history/genogram is also a good screening method to detect alcoholism.

V. Establishing the Diagnosis

When screening questions are positive, collect further information from history, physical, and laboratory tests. This is often done over several visits, if a crisis does not exist. Family members can often be helpful in providing information, but should only be contacted with the patient's knowledge and permission.

History:

There are many different ways to collect further history. Examples include:

MAST
Mnemonics — see Clark article on Medical Interview
Criteria from NCA or DSM IIIR
Meet with family members

Regardless of specific method, obtain data about:

1. loss of control of drinking
2. tolerance
3. withdrawal symptoms
4. blackouts
5. family history
6. adverse consequences on health, family, finances, legal
7. patient's belief about the problem

Physical: See clinical signs and symptoms.

Lab: Commonly used tests which are not necessarily diagnostic on their own , but can corroborate a clinical impression:

CBC - increased MCV, decreased platelets, anemia
GGT - increased

Liver enzymes - increased
Blood alcohol level

The diagnosis of alcoholism can be made when the information from these different sources indicates that the continued use of alcohol has caused significant interference with some important aspect of the patient's life.

References

1. National Council on Alcoholism. Criteria for the diagnosis of alcoholism. *Ann Int Med* 1972; 77:249-258
2. Clark WD. Alcoholism: Blocks to diagnosis and treatment. *Am J Med* 1981; 71:275-86.
3. Gallant DM. *Alcoholism. A guide to diagnosis, intervention, and treatment.* Norton & Company NY. 1987. (Chapters 1-5)
4. Clark WD. The medical interview: focus on alcohol problems. *Hosp Pract* 1985 (Nov): 59-68.
5. Milhorn HT. The diagnosis of alcoholism. *Am Fam Physician* 1988; 37:175-83.
6. Barnes HN, Aronson MD, Delbanco TL. eds. *Alcoholism: A guide for the primary care physician.* Springer-Verlog, New York, 1987.
7. Weinberg JR. Interview techniques of diagnosing alcoholism. *Am Fam Physician* 1974; 9:107-15.
8. Ewing JA. Detecting alcoholism: the CAGE questionnaire. *JAMA* 1984; 252:1905-7.
9. Holt S, Skinnor HA, Israel Y. Early identification of alcohol abuse: 2. Clinical and laboratory indicators. *Can Med Assoc J.* 1981; 124:1279-99.

Table 1

Clinical Symptoms and Signs of Alcohol Abuse

Symptoms and Signs	Stage of Appearance*	Diagnostic Value+
General Appearance		
Hand tremor	E	+
Excitability, irritability, nervousness	E	
Unkempt appearance	L	
Jaundice	L	+
Alcoholic facies	E	?
Mouth		
Coated tongue	E	
Periodontal disease	L	
Alcoholic fetor by day	E	+
Gastrointestinal tract		
Dyspepsia	E	
Morning nausea and vomiting	E	+
Recurrent diarrhea	E	
Recurrent abdominal pain	L	
Acute and chronic pancreatitis	E, L	+
Hepatomegaly	E	+
Splenomegaly	L	
Ascites	L	
Gastrointestinal bleeding	E, L	
Genitourinary System		
Polyuria	E	
Amenorrhea	L	
Impotence	E	
Face, Skin and Hands		
Rosacea, seborrheic dermatitis	L	
Parotid swelling	L	
Spider nevi	L	
Finger clubbing	L	
Dupuytren's contracture	L	+
Scars unrelated to surgical procedure	E	+
Cardiovascular and Respiratory System		
Palpitations	E	
Cardiomyopathy	L	
Hypertension	E	
Chronic obstructive airways disease	L	
Recurrent chest infection and pneumonia	L	
Central Nervous System		
Poor memory for recent events	E	
Blackouts	L	
Seizures	L	
Ataxia	L	
Peripheral neuropathy, myopathy	L	
Insomnia, nightmares	E	
Hallucinations	L	
Delirium tremens	L	
Wernicke-Korsakoff Syndrome	L	
Miscellaneous		
Trauma	E	+
Random blood alcohol level >65 mmol/l (300 mg/dl)	E	+
No gross incidents of intoxication with blood alcohol level > 33 mmol/l (150 mg/dl)	E	+

E = usually early; L = usually late; + = probably a good indicator of alcohol abuse.

Originally published in *Canadian Medical Association Journal* Vol. 15, May 15, 1981.

Table 2

Laboratory Markers of Excessive Alcohol, or Ethanol, Consumption

Marker	**Diagnostic Value**
Serum y-glutamyl transpeptidase level	Raised in 70% to 80% of alcoholic patients. Responds to ethanol consumption in excess of 40 to 60 g/d. Probably one of the best early indicators except in individuals with nonalcoholic liver disease and those taking other drugs.
Mean corpuscular volume	Raised in 75% to 90% of alcoholic patients. Appears to respond to ethanol consumption in excess of 60 g/d.
Serum high-density-lipoprotein Cholesterol level	Raised in 50% to 80% of alcoholic patients. Probably sensitive to moderate ethanol consumption (40 to 60 g/d) but not in patients with severe alcoholic liver disease.
Serum glutamate dehydrogenase level	Raised in alcoholic patients with severe liver disease and in aptients with fatty liver following excessive alcohol ingestion. Not responsive to consumption of 140 g/d for four weeks in normal individuals. Actual prevalence of abnormal values in alcoholic patients not clear.
Serum transferrin level	Raised in 81% of alcoholic patients who consume over 60 g/d of ethanol. Not present in patients with non-alcoholic liver disease and raised levels of serum glutamic oxaloacetic transaminase. Sensitive to low to moderate ethanol consumption. Quantitation and methodolic simplification of test methods should render this determination valuable.
Ratio of z-amino-n-butyric acid to leucine	Raised in some types of alcoholic patients but not in others. Apparently dependent on liver dysfunction and nutritional status.

Table 3

Michigan Alcoholism Screening Test (MAST)
(Including Point Values per Various Responses)

	Yes	**No**
0. Do you enjoy a drink now and then?	( )	( )
1. Do you feel you are a normal drinker? (By normal, we mean, do you drink less than or as much as most other people?)	( )	(2)
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	(2)	( )
3. Does your wife/husband, a parent, or other near relative ever worry or complain about your drinking?	(1)	( )
4. Can you stop drinking without a struggle after one or two drinks?	( )	(2)
5. Do you ever feel guilty about your drinking?	(1)	( )
6. Do friends or relatives think you are a normal drinker?	( )	(2)
7. Are you able to stop drinking when you want to?	( )	(2)
8. Have you ever attended a meeting of Alcoholics Anonymous (AA) for yourself?	(5)	( )
9. Have you gotten into physical fights when drinking?	(1)	( )
10. Has your drinking ever created problems between you and your wife/husband, a parent, or other relative?	(2)	( )
11. Has your wife/husband (or other family members) ever gone to anyone for help about your drinking?	(2)	( )
12. Have you ever lost friends because of your drinking?	(2)	( )
13. Have you ever gotten into trouble at work or school because of drinking?	(2)	( )
14. Have you ever lost a job because of drinking?	(2)	( )
15. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	(2)	( )
16. Do you drink before noon fairly often?	(1)	( )
17. Have you ever been told you have liver trouble? Cirrhosis?	(2)	( )
**18. After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, heard voices or seen things that really weren't there?	(2)	( )
19. Have you ever gone to anyone for help about your drinking?	(5)	( )
20. Have you ever been in a hospital because of drinking?	(5)	( )
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	(2)	( )
22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?	(2)	( )
***23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, how many times? ______)	(2)	( )
***24. Have you ever been arrested, or taken into custody, even for a few hours, because of other drunk behavior? (If YES, how many times? ______)	(2)	( )

**5 points for Delirium Tremens
***2 points for each arrest

Scoring System: In general, five points or more would place the subject in an "alcoholic" category. Four points would be suggestive of alcoholism, three points or less would indicate the subject was not alcoholic. Programs using the above scoring system find it very sensitive at the five point level, and it tends to find more people alcoholic than anticipated. However, it is a screening test and should be sensitive at its lower levels.

Source: Selzer ML, Vinokur A, van Rooijen L: A self-administered short Michigan alcoholism screening test (SMAST). J Stud Alcohol 36:117-26. Used with permission.

APPENDIX B

Conference #2

ALCOHOLISM: PRESENTING THE DIAGNOSIS AND WORKING WITH DENIAL

I. Presenting the Diagnosis:

1. Share concern about patient's substance abuse at whatever level of certainty the data supports. If you suspect alcoholism, present the diagnosis in a respectful way.

   eg,"I am concerned about your drinking"

   I believe that your use of alcohol may be contributing to your symptoms"

   Alternatively, ask the patient what he or she feels is causing the problem or if the patient feels that he or she has a drinking problem.

2. Present the specific data from patient's history, physical, and laboratory work that support the diagnosis.

3. Explain and educate the patient about alcoholism as a disease, comparing it to other chronic medical illnesses. Inquire about the patient's concept of alcoholism.

   Using the term "drinking problem" is often a less threatening way to introduce this diagnosis. However, at some point, the term "alcoholism" is used so as to remove any ambiguity about the diagnosis. It could be used initially to ask about other family members before applying it to the patient. Explanation of the disease model of alcoholism will help alleviate guilt and shame.

4. Be respectful of the patient. Try to reduce feelings of shame, guilt, and fear. Avoid being judgmental. Acknowledge the patient's feelings and reactions to the diagnosis.

5. Discuss available treatment options. Express optimism and hope for recovery. Avoid advice to "cut down" or "abstain" from drinking as the sole treatment. Make referral to a treatment center or AA. If the patient is cooperative, call a treatment resource while the patient is still present and give the phone to the patient.

6. Remember that alcoholism is a family illness and all members need treatment. At some point, a family meeting will be necessary. The timing will vary with physician preference and circumstances. Always get the permission of the patient to involve other family members.

   Perhaps only 50% of patients will accept your diagnosis when first presented, and even fewer will accept treatment. This is part of the illness and should be expected. Do not be discouraged. You "plant the seed" that will lead to acceptance and treatment several months or years later.

Remember Mnemonic SOAPE

S Support: "I'm with you", "I'm here to help you"
O Optimism: Always the potential for positive change and recovery
A Absolution: Relieve some of the moral overtones
P Plans: Specific negotiating of treatment options
E Explanatory: Disease concept of alcoholism

II. Working with Denial

Frequently patients do not accept the diagnosis of alcoholism. Possible strategies to deal with denial include:

1. Repeat the diagnosis and supporting data.
2. Family interview to collect more information about consequences of drinking (see references — Baird).
3. Trial of controlled drinking or abstinence, with agreement to enter treatment if unsuccessful.
4. "Educational" visits to Alcoholics Anonymous--at least three different meetings, then report back to you. Expect resistance.
5. Further assessment with substance abuse counsellor (joint visit at HCFM or referral to Dana Harlow at Lakeland) for a "second opinion."
6. Formal intervention coordinated by substance abuse counsellor. This requires the cooperation of at least some family members.
7. Refer family members to Al-Anon or Ala-Teen even if patient refuses treatment.
8. Be respectful of patient and maintain continuing relationship. Working through denial may take several years and often occurs only when a crisis develops. Keep an open door policy.

III. Other Tips

1. Be honest. Record the diagnosis in the chart. If we deny the problem by avoiding the use of realistic diagnostic terms, how can we expect the patient and family to come to grips with this problem?
2. Presenting the diagnosis and confronting denial may be an extended process. Work with the patient. Even though you might not "succeed" immediately, you probably will change the way the patient thinks about his/her drinking. The average time for a patient in denial to enter treatment may be one to two years.
3. Offer continued support; be positive about recovery and avoid becoming judgmental.
4. Accept the fact that some patients may continue self-destruction. Responsibility for change has been returned to the patient and patient's family.

References

1. Baird AM. Chemical dependency: a protocol for involving the family. *Fam Sys Med* 1985; 3:216-220.
2. "Primary care family counselling for chemical dependency" in Doherty WI and Baird MA. *Family Therapy and Family Medicine*, Guilford Press, NY; 1983; p197-203.
3. Clark WD. The medical interview: focus on alcohol problems. *Hosp Pract* 1985; Nov: 59-68.
4. Weinberg JR. Interview techniques for diagnosing alcoholism. *Am Fam Physician* 1974; 9:107-115.
5. Barnes HN, Aronson MD, Delbanco TL, eds. *Alcoholism: A guide for the primary care physician*. Springer-Verlag, New York, 1987. (Chapters 6&7).

Benjamin W. Goodman, Jr., MD

The Impaired Health Professional: A Curriculum Project for PGY-I Residents

CONTENTS

Page

Curriculum Example Description 47

Appendices:

Clinical Case Vignettes 48

Pilot Notes: Seminar on The Chemically Dependent Physician 49

Semantic Differential Test 50

The Chemically Dependent Physician: Objective Knowledge Test 51

41

Benjamin W. Goodman, Jr., MD
Medical Arts Clinic
24 Second Ave. NE
Hickory, N.C. 28601
(704) 328-2231

THE IMPAIRED HEALTH PROFESSIONAL:

A Curriculum Project for PGY-1 Residents

Context:

This project occurs during a special stress reduction rotation for 13-15 family medicine residents. The rotation is situated at the midpoint of internship (February). Initially planned for family medicine residents, the project can be broadened to include residents from other disciplines as well as medical students.

Rationale:

Physician impairment from substance abuse is a serious health problem affecting 4%-9% of physicians at some point during their careers. Rates of opiate and sedative addiction are higher in physicians than in the general population. Depression often is an antecedent condition. Suicide can be the end result of untreated addiction.

Objectives:

1. Residents improve their cognitive knowledge of physician impairment by substance abuse by:
   a. Identifying the epidemiology of such impairment.
   b. Recognizing specialty areas at high risk.
   c. Recalling three of five risk factors.
   d. Discussing drug categories most likely to be abused.
   e. Understanding the intense denial usually exhibited by physician addicts.
   f. Characterizing two forms of addiction seen in physicians, contrasting each form to the classic "street addict."
2. The resident recognizes the need for a structured treatment program and aftercare follow-up for the addicted physician.
3. The resident understands the favorable prognosis for addicted physicians completing therapy.
4. The resident recognizes three of five factors which produce significant stress on family physicians and elaborates at least one strategy for dealing with each.
5. The resident identifies signs/symptoms of early substance abuse by a physician and demonstrates willingness to confront an impaired colleague, using a matter-of-fact attitude and showing personal and professional respect.
6. Resident recognizes the similarity between the psychological state of a stressed intern and a physician most susceptible to substance abuse--by identifying at least two of four comparable characteristics (equivocal self-esteem, unmet dependency needs, feelings of isolation and loneliness).
7. The resident and his/her spouse demonstrate self- awareness of personal risk to addiction, improvement in their strategies for coping with stress, and more willingness to ask for help.
8. The resident illustrates a nonjudgmental attitude toward the physician-addict.

Instructional Strategies:

A. Clinical case vignettes are used by five triadic small groups (role-playing doctor, physician- patient, observer) during a two-hour seminar. Cognitive knowledge covered by objectives 1-5 incorporated into these vignettes and the ensuing discussion (Appendix A).

B. Seminars designed for interns and their spouses address risk factors for physician addiction, construct family genograms, and discuss alternate strategies for coping with stress. Led by a physician-substance abuse counselor/ marriage counselor, these seminars occur during separate half-day sessions (Appendix B).

C. An interview session with a recovering physician addresses objective 8.

Educational Materials:

A. Texts:

Scheiber SC, Doyle BB, eds. *The Impaired Physician*. Plenum Medical Book Co; NY, 1983.

Twerski AJ. *It Happens To Doctors, Too*. Hazelden; Center City, MN, 1982.

Gerber LA. *Married to their Careers: Career and Family Dilemmas in Doctor's Lives*. Tavistock Publications; NY, 1983.

B. The Impaired Physician: A Faculty Handbook (Allen Dietrich, Dartmouth, 1986) contains impairment vignettes.

C. Selected bibliography of journal articles from recent literature

D. Recovering physician.

Evaluation: (See Appendix C and D)

1. Pre- and post-test Fisher Semantic Differential-- labeling one case "Physician Addicted to Opiates;" repeat testing six months later, after residents have completed internship.
2. Pre- and post-test with locally constructed, NBME- style examination (25 questions) focused on factual data concerning physician impairment due to substance abuse; repeat testing six months later.
3. Pre- and post-test: "Describe 10 strategies you might use to deal with stresses accumulated during a hard day at work;" six months retesting.

Faculty Development: The subject itself should interest faculty colleagues. By providing them a two to three page synopsis of the subject, one can encourage their participation in the triadic role playing session.

APPENDIX A

Case 1

Anesthesiologist Patient:

You're a 40-year-old anesthesiologist in a community hospital. Son of alcoholic parents, you have used alcohol regularly (one to two beers daily) since age 20. You have begun to use meperidine (Demerol) twice weekly, injecting 100-250 mg intravenously at night. Valium 10 mg BID helps you "calm your nerves" before complicated cases.

Things have become chaotic at home. Your wife, Eunice, has just left you after 15 years of marriage. Your use of Demerol has accelerated to nightly use during this tense two weeks, but you've promised yourself to return to a lower frequency of use "as soon as the stress slacks up."

Work has become problematic, too: pre-op patients have complained of your rude, surly attitude; your charting in the recovery room has been incomplete on several patients; you recently missed the first surgical case of the morning.

You are visiting your doctor today, because hospital colleagues have expressed concern about your health. You see "fatigue" as the major problem. You've thought of hepatitis as a possibility, but think it unlikely. Perhaps some Valium (or Xanax) would help you cope with current stress. . .

Case 2

Physician:

Dr. Rolf is a 40-year-old anesthesiologist at your local hospital. You've heard hospital rumors about his erratic performance recently. Your nurse knows his wife and alerts you that their marriage is chaotic.

His chief complaint is "fatigue." The medical director of the hospital has called you--off the record--and asked you to be very thorough in your evaluation.

Can you identify his problem and set up a reasonable management plan?

Case 3

Suspected physician:

You're a 55-year-old professor of surgery, who has worked at MUSC for 25 years. You are married (35 years) and have three adult children. You have been drinking actively for 20 years. Within the past 12 years, your alcohol intake has increased. You often are late for rounds, drink three to five beers after morning rounds, sleep for several hours, and return to work at 4:00 p.m. You have fallen behind in reading current literature. You often find it takes several drinks before surgery to "calm your tremor."

You have been accused before (five years ago) of alcoholism. You won that episode by virtue of your codependent wife's denial, and your internist's explanation that you were "ketotic" from your anti-hypertensive medications.

You resist diagnosis initially, but know it's time for treatment.

Case 4

Physician:

You are residency director of a family medicine program. One of your residents suspects that a faculty clinician in another department is an alcoholic. He cites frequent episodes of poor clinical judgment (often quickly corrected by a colleague), daytime unavailability, several episodes of ataxia, and slurred speech at work. An odor of alcohol has been detected despite the subject's use of mouth spray.

You are now talking to the suspected alcoholic, Dr. Vance, a 55-year-old surgeon who has been employed at MUSC for 25 years. Your objective is to discuss this situation, expressing concern, and arriving at an appropriate decision for further management.

APPENDIX B

PILOT NOTES

Seminar: "The Chemically Dependent Physician"
An STFM Faculty Development Project
by Ben Goodman, MD,
and Martha Tumblin, MEd

Session 1:

The first session occurred February 10, 1988, from 8:30-11:00 a.m. Twelve of 13 PGY-1 residents and three spouses attended. The major educational objective was the introduction of information about the addicted physician by way of role playing vignettes.

The class began with pre-testing of attitudes and cognitive knowledge. Three instruments were used:

A. Chappel's Substance Abuse Attitude Survey (SAAS): a 50-item survey of general attitudes about addictive diseases and their management.

B. A modified version of the Fisher Semantic Differential (where the three patients to whom 16 personality characteristics are ascribed become three physicians: normal, diabetic, and chemically dependent physicians).

C. A 21-item National Board of Medical Examiners type test which was created especially for this curriculum module. Each item deals with major aspects of physician addiction: epidemiology, specialties of high risk, characteristics of addicted physicians, drugs of addiction, etc.

Testing took longer than expected (45 min.), but was deemed an essential starting point for our teaching.

Three cases vignettes then were presented to small groups of five persons. Initial plans called for five cases to be presented to five three-person groups, but only three cases were finalized by the time of class. Case vignettes included: a) a second-year family medicine resident, adult child of an alcoholic father, who presents with insomnia, family and job pressures, and recent nightly use of alcohol to cope; b) a faculty clinician from another department who is suspected of alcoholism by one of your interns due to his erratic job performance; and, c) an anesthesiologist who complains of fatigue and is experiencing scrutiny for poor job performance, who has developed a poly-drug addition (meperidine, diazepam, and alcohol) to cope with these stresses.

Twenty minutes were allotted to each case, with one resident being the patient, one the dependent physician, and three acting as observers. Participants were then given 5-10 minutes to writedown their observations, feelings, and personal reactions to the role play. Each small group then had 20 minutes to discuss the case, focusing on both personal feelings and clinical content. Each participant was asked directly, "How did you feel during and at the end of this case exercise?"

The entire class then was reassembled, and each small group read doctor and physician scripts and summarized their group reaction. Faculty preceptors (Dr. Goodman, Ms. Tumblin) annotated the discussion of each case with factual data represented as questions on the pre-test exam. This wrap-up session was very lively and took 30-40 minutes.

Follow-up to Session 1:

A copy of the chapters on the addicted physician from the *STFM Handbook of Substance Abuse Curriculum* was distributed to each of these 12 PGY-1 residents later that day. This document served as a template for many of the pre- post-test examination questions. Although residents were not told this, it was hoped that reading this chapter might reinforce the major points of the day's seminar.

Interim Preparation for Seminar 2:

The second session was to occur on February 24, and be highlighted by an interview with a recovering physician. Calls to the Impaired Physician Committee of the state medical society had been greeted with polite support for the idea, and a promise to ask for a physician volunteer at the next Caduceus Club meeting (8-10 active physician members). No volunteer appeared. Ms. Tumblin put out a similar request through an AA contact--and almost as if planned, a physician called us on February 9. We met him for lunch soon after our first seminar and shared our educational objectives with him. We gave him copies of our pre- test instruments and Dr. Fisher's chapter concerning CD physicians. Initially quite anxious, since he knew neither of us, this recovering physician gradually warmed up to our idea of stress reduction for interns and our comparison of the psychological vulnerabilities of an intern and a physician at high risk for addiction. Unknown to us, however, were the specific details of his addiction or the length of his recovery. We felt better not pressing for these details. At some level, we left our 90-minute lunch feeling he understood our basic objectives and trusted us.

Seminar 2:

We planned several activities for this two-hour session (9-11 a.m.):

- Live interview with our recovering physician.
- Viewing "Thanks for the One Time" videotape, which focuses on a physician's alcoholism and culminates in family confrontation.
- Administration of The Professional Enablers Questionnaire.
- Post-testing.

This agenda proved unrealistic, and we pared it down. The live interview was so successful that all other plans were cancelled in a "go with the flow of what's working" decision. After a brief overview of his addiction (his initial request for help was thwarted by a psychiatrist who exclaimed, "You don't drink anymore than I do!"), four treatment failures, including Ridgeview Institute, and his brief, but seemingly solid 15 month recovery), our guest physician answered questions from the residents. This was one of the most electrifying teaching sessions I've seen: Residents were on the edges of their chairs, the recovering doctor was open and honest in his responses. The class formulated a letter that was mailed to our guest the day after his visit. I called him later the same day and thanked him for his participation.

- Post-testing materials were given out at the end of the session, and residents were asked to complete them at home and return them within 48 hours. At 48 hours, only three of 13 had returned the surveys, but within a week, 12/13 had completed them. The final post-test was returned after several phone calls and notes about two weeks later.

APPENDIX C

Please respond on the semantic differential you have been given, according to your feelings, for each person. Check one space on the continuum between the adjectives. The closer the check is to either pole, the more closely your response i[illegible] agreement with that adjective. A check in the middle is a neutral response.

The chemically dependent physician is:

FOOLISH	______	______	______	______	______	______	______	WISE
WEAK	______	______	______	______	______	______	______	STRONG
PASSIVE	______	______	______	______	______	______	______	ACTIVE
MYSTERIOUS	______	______	______	______	______	______	______	UNDERSTANDABLE
SICK	______	______	______	______	______	______	______	HEALTHY
FEMININE	______	______	______	______	______	______	______	MASCULINE
EXCITABLE	______	______	______	______	______	______	______	CALM
STRANGE	______	______	______	______	______	______	______	FAMILIAR
DANGEROUS	______	______	______	______	______	______	______	SAFE
DELICATE	______	______	______	______	______	______	______	RUGGED
TENSE	______	______	______	______	______	______	______	RELAXED
COMPLICATED	______	______	______	______	______	______	______	SIMPLE
HOPELESS	______	______	______	______	______	______	______	HOPEFUL
FEEBLE	______	______	______	______	______	______	______	VIGOROUS
AIMLESS	______	______	______	______	______	______	______	MOTIVATED
UNPREDICTABLE	______	______	______	______	______	______	______	PREDICTABLE

Please respond on the semantic differential you have been given, according to your feelings, for each person. Check one space on the continuum between the adjectives. The closer the check is to either pole, the more closely your response is in agreement with that adjective. A check in the middle is a neutral response.

The diabetic physician is:

FOOLISH	______	______	______	______	______	______	______	WISE
WEAK	______	______	______	______	______	______	______	STRONG
PASSIVE	______	______	______	______	______	______	______	ACTIVE
MYSTERIOUS	______	______	______	______	______	______	______	UNDERSTANDABLE
SICK	______	______	______	______	______	______	______	HEALTHY
FEMININE	______	______	______	______	______	______	______	MASCULINE
EXCITABLE	______	______	______	______	______	______	______	CALM
STRANGE	______	______	______	______	______	______	______	FAMILIAR
DANGEROUS	______	______	______	______	______	______	______	SAFE
DELICATE	______	______	______	______	______	______	______	RUGGED
TENSE	______	______	______	______	______	______	______	RELAXED
COMPLICATED	______	______	______	______	______	______	______	SIMPLE
HOPELESS	______	______	______	______	______	______	______	HOPEFUL
FEEBLE	______	______	______	______	______	______	______	VIGOROUS
AIMLESS	______	______	______	______	______	______	______	MOTIVATED
UNPREDICTABLE	______	______	______	______	______	______	______	PREDICTABLE

Please respond on the semantic differential you have been given, according to your feelings, for each person. Check one space on the continuum between the adjectives. The closer the check is to either pole, the more closely your response is in agreement with that adjective. A check in the middle is a neutral response

The average physician is:

FOOLISH	______	______	______	______	______	______	______	WISE
WEAK	______	______	______	______	______	______	______	STRONG
PASSIVE	______	______	______	______	______	______	______	ACTIVE
MYSTERIOUS	______	______	______	______	______	______	______	UNDERSTANDABLE
SICK	______	______	______	______	______	______	______	HEALTHY
FEMININE	______	______	______	______	______	______	______	MASCULINE
EXCITABLE	______	______	______	______	______	______	______	CALM
STRANGE	______	______	______	______	______	______	______	FAMILIAR
DANGEROUS	______	______	______	______	______	______	______	SAFE
DELICATE	______	______	______	______	______	______	______	RUGGED
TENSE	______	______	______	______	______	______	______	RELAXED
COMPLICATED	______	______	______	______	______	______	______	SIMPLE
HOPELESS	______	______	______	______	______	______	______	HOPEFUL
FEEBLE	______	______	______	______	______	______	______	VIGOROUS
AIMLESS	______	______	______	______	______	______	______	MOTIVATED
UNPREDICTABLE	______	______	______	______	______	______	______	PREDICTABLE

APPENDIX D

The Chemically Dependent Physician

Each of the following questions has been designed to analyze your knowledge about this important subject.

Please take a few moments and answer each question as accurately as you can. We will address each item noted during the seminar.

- Each of these is a K-type question. Remember the answer

A = 1, 2, 3 items correct
B = 1, 3 items correct
C = 2, 4 items correct
D = only item 4 correct
E = all of the above correct

- Many of the characteristics of physicians especially vulnerable to substance abuse problems are shared by interns midway through internship. Of the following, which are accurate:

1. Feelings of isolation and loneliness
2. Unmet dependency needs
3. Poor self-image
4. Sensitive, slightly introverted personality

Answer: __________

- Which of the following specialties seem to be overrepresented in the statistics for chemically dependent physicians (ie, specialties of high risk for addiction)?

1. Psychiatry
2. Family medicine
3. Anesthesiology
4. Neonatologists

Answer: __________

- Age peaks for substance abuse by physicians include which of the following?

1. Age 30-40: before establishing a successful practice
2. Age 25-30: during and after specialty training
3. Age 50-65: after 15-20 years of successful practice
4. Age 70-75: approximately time of retirement

Answer: __________

- Several fundamental barriers--each of which is treatable--to diagnosis and treatment of the chemically dependent physician have been identified. Which of the following are correct?

1. A trained addictionologist must be involved at this stage
2. It's hard for the addicted physician to ask for help
3. Drug Enforcement Agency (DEA) laws and regulations
4. Physicians are reluctant to confront a colleague on this issue

Answer: __________

- As medical director of a large clinic, you serve as director of the physician recruitment committee. Which of the following items might suggest a drug problem in a physician applicant?

1. Presence of moustache and/or beard
2. Unexplained time lapse in work history
3. Laconic, somewhat brusque manner
4. Frequent job changes

Answer: __________

- As one of your duties within your local hospital, you are a member of the Ethics Committee. Concern has been raised about the performance of one of the physicians with privileges at your hospital. Which of the following observations suggest a chemical dependency problem in this physician?

1. Inappropriate orders in charts
2. Often late or absent from monthly hospital staff meetings
3. Often unavailable when on call
4. Delinquent discharge summaries

Answer: __________

- Specific clues which suggest impairment of the health professional (physician, nurse, psychologist, etc.) include which of the following home and family conditions?

1. School problems (often with drugs) in children
2. Spouse taking psychoactive medication
3. Sexual problems with spouse
4. Mood swings

Answer: __________

- You are a family physician working as a member of a 25- physician health maintenance organization (HMO). At lunch, you hear a rumor from one of the staff that concern exists within the HMO that one or more of the physicians is chemically dependent.

Which of the following items are manifestations of physician dependency that might be observed at the office?

1. Intolerance to changes in schedule
2. Decreased work load
3. Frequent absences, or days off for vague reasons
4. Patient complaint

Answer: __________

- The impaired health professional may manifest his/her addiction by changes in clinical behavior. Which of the following categories of changes suggest such a state?

1. Cannot maintain his/her prior level of functioning (even if currently functioning adequately)
2. Cannot effectively promote health through interpersonal skills
3. Cannot maintain skills by continuing medical education activities
4. Cannot offer reasonable patient care

Answer: __________

- The daughter of a local physician expresses concern about her father, a 52-year-old family physician who has practiced family medicine for 18 years. She believes that her father's recent recurrent insomnia, his frequent arguments with her mother, and his neglect of Rotary Club meetings are early clues to addiction.!

Which of the following management option(s) would be most appropriate?

1. Ask the daughter to fill out a Children of Alcoholics Screening Test (CAST)
2. Contact the state medical society and their Impaired Physicians Committee for advice
3. Refer the daughter to local Al-Anon group
4. Reassurance: these are nonspecific observations and not reasons for alarm

Answer: __________

- **Match each of the categories described in Column A with the most accurate statistic in Column B:**

		Column A		**Column B**
________	1.	Subset of total physicians who will become addicted during their lives	A.	Rate 30-100 times higher than general population
________	2.	Alcoholism will develop in ________% physicians during their lives	B.	Rate 3 times higher than general population
________	3.	Opiate addiction among physicians	C.	35%
________	4.	Of addicted physicians, subset who will have multiple chemical dependencies	D.	4%-9%
			E.	More than 50%
			F.	15%-19%
			G.	7%

- Match each of the four principal causes of chronic physician impairment in Column A with the most appropriate percentage in Column B. (Items in Column B may be used more than once.)

		Column A		Column B
________	1.	Chemical dependence	A.	2%
________	2.	Physical illness	B.	85%
________	3.	Senility	C.	5%-10%
________	4.	Mental illness		

- List 10 strategies you use to cope with stress:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________
9. ______________________________________
10. ______________________________________

- Which one of the following items has been associated with psychoactive drug use by physicians? Select the single best answer:

1. Antisocial attitude
2. Compulsion for perfection
3. Depression
4. Nonmembership in AMA
5. Impulsivity

Answer: ____________

- Name the three drug categories most abused by the addicted physician:

1. ____________________
2. ____________________
3. ____________________

- Which of the following statements about chemical dependence in health professionals are true:

(1) T F Addicted physicians usually differ from the "typical addict" in age, patterns of socialization, and purpose of their abuse.
(2) T F 15% of all addicts are physicians
(3) T F 15% of all addicts are either nurses or pharmacists
(4) T F Levels of physical dependence may be very high in the physician addict
(5) T F Denial (by colleagues, society, and self) often is one of the most powerful barriers to diagnosis of physician addiction
(6) T F 50% of chemically dependent physicians have at least one addicted parent
(7) T F The addicted physician is at high risk for suicide
(8) T F Physicians in an academic setting and those doing direct patient care may be high-risk subsets for addiction
(9) T F Self-treatment often starts a physician's nonmedical use of medication and becomes the first step toward dependency
(10) T F Physicians often act as enablers to their patients and foster addiction by their prescribing habits
(11) T F Physicians who want to stop enabling patients to remain enmeshed in their addiction should update their knowledge of addiction, attend a local AA or Al-Anon meeting, and work to get some of their patients into treatment

- You are a family physician who works as an occupational health consultant for a large industry in your community. One of your duties is the operation of a daily "sick call" clinic for employees of this firm. The patient today is the firm's psychologist. He complains of back and chest pains, both severe enough to cause insomnia. Physical examination is normal except for mild tremor, mydriatic pupils, and heart rate of 106. He has no regular physician, even though he admits that five visits to the local emergency room have occurred within the past six months. These have been attributed to agoraphobia. He has been treated with alazopram (Xanax) in the past and requests a refill of this now.

  Which of the following analyses best summarizes this case?

  1. Agoraphobia, inadequate treatment
  2. Agoraphobia, with frequent benzodiazepine withdrawal states
  3. Cocaine (or other CNS stimulant) abuse
  4. Hyperventilation syndrome

  Answer: ____________

- Which of the following represents the most useful definition of an "impaired physician?" Select the single best answer:

  1. A physician who cannot manage an office practice without experiencing stress or anxiety
  2. A physician whose personal problems interfere with patient care, education, or personal life
  3. A physician with repetitive and progressive use of alcohol or narcotics

  Answer: ____________

- The Georgia Disabled Doctor's Program often is cited as an exemplary treatment plan for addicted physicians. Its program uses a multidisciplinary treatment team--including recovering physicians--high levels of confrontation, staged rehabilitation through residential halfway houses, and mandatory follow-up. What is the prognosis for a physician receiving such treatment (successful outcome being defined as a return to drug-free living and the practice of medicine)?

  Check the single most appropriate figure:

  1. 10-15%
  2. 30-40%
  3. 70-85%
  4. Slightly less than 50%
  5. 95%

  Answer: ____________

- In most instances, the physician addict differs from the prototype of the "street addict." One distinct difference is the reasons cited as rationale for initial drug use. The majority of physicians (versus only 8% of street addicts) noted one or more of five reasons. One reason was fatigue. Can you name the other four?

  1. ____________________
  2. ____________________
  3. ____________________
  4. ____________________

- Which of the following have been identified as risk factors for addiction in physicians? Check all that apply.
- Which of the following have been identified as risk factors for addiction in physicians? Check all that apply.

  ________ Childhood physical illness or emotional deprivation
  ________ Career frustration
  ________ An adult child of an alcoholic parent
  ________ Limited number of ways used to alleviate (cope with) distress
  ________ Family history of chemical dependency

Reference: *Can Fam Phys* 28:851-53, 1980 (original source *J Kansas Med Soc* 1978; 79:601-604)

48

J. Paul Seale, MD

Planning and Implementing a Part-Time PG-I Resident Rotation in Substance Abuse

CONTENTS

Page
Curriculum Example Description 55
Appendices:
Substance Abuse Manual for Family Practice Residents 58
Case Video Evaluation 59
Alcoholism and Drug Abuse Survey 60
Evaluation of the Casa del Sol Rotation 61
Orientation for Simulated Patients 62
Simulated Patient Interviews 62
Block Schedule of Resident Activities, Casa del Sol Rotation 63

J. Paul Seale, MD
Department of Family Practice
University of Texas Health Science Center
at San Antonio
7703 Floyd Curl Drive
San Antonio, TX 78284-7795
(512) 270-3911

PLANNING AND IMPLEMENTING A PART-TIME PG-I RESIDENT ROTATION IN SUBSTANCE ABUSE

CONTEXT

Setting: Family Practice Residency Program, university based. Teaching and clinical care for this rotation occur outside the medical center at Casa Del Sol, an inpatient treatment facility.

Level of Participants: First-year residents

Contact Time: 26 to 32 hours

How Tied into Overall Curriculum: Each PG-I resident spends 20% of his/her time at Casa Del Sol during the one-month Community Health rotation.

Scope of Substances Covered: Both alcohol and other drugs.

RATIONALE

Barriers to successful resident training in substance abuse include attitudinal barriers to productive interaction with substance abuse patients, a lack of knowledge and skills in this area, and a backlog of negative experiences with such patients. The purpose of this rotation is: (1) to provide each resident with a basic fund of knowledge in the area of substance abuse; (2) to develop skills in history taking and primary care intervention; and, (3) to provide positive encounters with substance abusing patients which may help to change negative attitudes. The hypothesis is that teaching practical skills in diagnosis and intervention will result in increased diagnosis and referral of substance abuse patients, even if changes in attitudes are minimal to moderate. Effective implementation will require increased knowledge and skills of all faculty in this area and intensive training for five faculty members who will serve as faculty preceptors.

OBJECTIVES

A. **Resident**

Knowledge:

(1) Recognize counterproductive attitudes and behaviors of physicians toward substance abuse patients

(2) Recognize the common medical complications of substance abuse, especially alcoholism

(3) Explain why substance abuse may be viewed as a family illness, and describe implications for the family physician

(4) Describe the major components of an inpatient substance abuse treatment program

Skills:

(1) Demonstrate skills in early diagnosis and intervention in ambulatory substance abuse patients

(2) Manage the common medical complications of substance abuse, especially alcoholism

Attitudes:

(1) Recognize counterproductive attitudes and behaviors of physicians toward substance abuse patients

(2) View substance abuse as a treatable disease

(3) Recognize an obligation to treat substance abusing patients in spite of the negative attitudes which they sometimes engender

B. **Faculty**

Knowledge:

Meet the knowledge objectives described above for residents

Skills:

(1) Demonstrate the skills noted above for residents

(2) Conduct a series of five seminars on substance abuse for residents

(3) Precept residents at Casa Del Sol with ease

Attitudes:

(1) Demonstrate the attitudinal changes noted above for residents

(2) See substance abuse as a significant content area which should be addressed with residents in the clinical setting, when appropriate

INSTRUCTIONAL STRATEGIES AND ACTIVITY SEQUENCE

Week 1

Day 1--Orientation to treatment center, participation in patient staffing as an observer.

Day 2--Conference =1: Discuss previous experience with substance abuse patients and/or treatment programs; discuss barriers to effective treatment of substance abuse patients using a case description of a difficult patient as a focal point, discuss epidemiology of substance abuse including prevalence, prognosis, and recovery rate; and discuss attitudes which promote constructive interaction with substance abuse patients.

History, physical evaluation, and MAST on one to two new inpatients.

Resident is videotaped interviewing a simulated patient. (Counselors from the treatment program serve as simulated patients.)

Day 3--Attendance at weekly community meeting at treatment center.

Week 2

Day 1--Attend patient staffing, with resident presenting any patients worked up the previous week. Second hour may be used for further participation in patient staffing, or interviews and review of laboratory data with patients evaluated the previous week.

BEST COPY AVAILABLE

Day 2--Review videotape with behavioral scientist.

Conference on early diagnosis and intervention.

History, physical, and MAST on one to two additional patients.

Day 3--Attendance at Alcoholics Anonymous meeting with recovering physician; residents who have previously attended Alcoholics Anonymous may choose to attend Narcotics Anonymous, Cocaine Anonymous, Al-Anon, or Adult Children of Alcoholics meeting.

Week 3

Day 1--Resident presents patients worked up in the previous week at patient staffing. Second hour may be used for further participation in patient staffing, or interviews and review of laboratory data with patients.

Day 2--Brief discussion of resident's experience at 12-step meeting the previous week.

Conference on alcohol detoxification.

History, physical, and MAST on one to two additional patients.

Day 3--Participation in two-hour group meeting at treatment center.

Week 4

Day 1--Presentation of patients worked up the previous week at patient staffing. Second hour may be used for further participation in staffing, or interviews and review of laboratory data with patients.

Day 2--Conference on family issues in substance abuse.

History, physical, and MAST on one to two new patients.

Day 3--Second simulated patient interview (videotaped), using a volunteer from the community who is now in recovery.

Week 5

Day 1--Presentation of patients worked up the previous week at patient staffing; second hour may be used for further participation in patient staffing, or interviews and review of laboratory data with patients.

Day 2--Formal and informal evaluation of the rotation.

Conference on common drugs of abuse, focusing on drug(s) of the residents' choice.

History, physical, and MAST on one to two new patients.

INSTRUCTIONAL MATERIALS AND RESOURCES

Readings:

Barnes HN, Aronson MD, et al. *Alcoholism: A guide for the primary care physician*. New York: Springer-Verlag, 1987. (Reference text only).

Audiovisual Aids:

1. Alcoholism: What are we missing? Recent developments in diagnosis and treatment of alcoholism. J Paul Seale, M.D., The University of Texas Health Science Center at San Antonio, San Antonio, Texas, 78284-7795.
2. Alcohol detoxification. Michael Fleming, M.D., University of Wisconsin, School of Medicine, Madison, Wisconsin, 53715.
3. Soft is the heart of a child. Hazelden Educational Materials, P.O. Box 176, Center City, Minnesota, 55012.
4. Cocaine: highs and lows. FMS Production, Inc., P.O. Box 4428, Santa Barbara, California, 93140.
5. Medical aspects of mind-altering drugs. Max Schneider, M.D. FMS Productions, P.O. Box 4428, Santa Barbara, California, 93140.

Materials Developed Specifically for this Component:

1. Videotapes--See #1 and #2 above.
2. Syllabus: Substance Abuse Manual for Family Practice Residents. (See appendix for contents).
3. Connecting with Substance Abuse Treatment Resources in San Antonio (a directory of locally available substance abuse treatment resources).

Faculty/Instructors:

1. Family Physician Faculty: five (Minimum one, ideally two or more)
2. Behavioral Scientist Faculty: two (Minimum one, ideally two or more)
3. Substance Abuse Treatment Counselors: four (Number varies according to staffing of treatment center. Ideally two or more.)

Other Necessary Materials and/or Resources:

1. Video recorder.
2. Video playback monitor.
3. Simulated patients: 10 (minimum two, ideally 5-10.)

EVALUATION STRATEGIES AND INSTRUMENTS

A. **Resident Evaluations**

Strategies:

1. Assessment of resident attitudes at 0, 1, and 6 months.
2. Videotape simulated patient interview at 0, 1, and 6 months.
3. Longitudinal monthly recall survey of number of substance abuse patients seen and number of substance abuse referrals attempted by residents (Note: Residents not participating in the rotation are also being surveyed.)
4. Overall evaluation of the rotation by each resident at the end of the month.

Instruments:

1. Substance Abuse Attitude Survey. Chappel JN, Veach TL, et al. School of Medicine, University of Nevada.
2. Case Video Evaluation (see appendix).
3. Alcoholism and Drug Abuse Survey (see appendix).
4. Evaluation of the Casa Del Sol rotation (see appendix).

B. **Faculty Evaluation**

Strategies:

1. Substance abuse knowledge survey at 0 and 12 months.
2. Self-perception of competence and interest in specific substance abuse topic areas at 0 and 12 months.
3. Qualitative interview with Casa preceptors at 12 months.

Instruments:

1. Understanding alcoholism. Weinberg and Morse, Mayo Clinic School of Medicine, Rochester, Minnesota.
2. Faculty development questionnaire. Project ADEPT Working Committee, Brown University.

ORGANIZATIONAL CONSTRAINTS

Constraints

1. Limited curriculum time.

   Suggestions to Overcome
   Plan a part-time elective (only two half-days/week), which can share a curriculum slot with another rotation; limit and focus goals; set aside specific time slots for teaching conferences.

2. Cost of audiovisual material.

Suggestions to Overcome
Ask local treatment facilities to donate one videotape each; offer to share cost with university or hospital library; obtain grant funding.

3. Limited faculty expertise.

Suggestions to Overcome
Plan an organized faculty development program, including grand rounds presentations, incorporation in ongoing faculty development conference series, participation in annual department Family Practice Recertification Review; ask department chair to authorize recruitment of other preceptors for this rotation, with appropriate reward such as comp time; recruit faculty volunteers to be trained as preceptors in substance abuse; arrange departmental contract to provide medical evaluation services which will require faculty to upgrade knowledge and skills.

3A. Limited time available for faculty training

Suggestions to Overcome
Lobby for time in ongoing conferences, such as grand rounds, faculty development, family practice review course, etc.; schedule occasional half-day, intensive workshops; schedule monthly meetings with co-preceptors to cover content and process issues; identify treatment centers (especiallyWillingway Hospital, Statesboro, GA) willing to provide one- week intensive faculty development experiences.

3B. Lack of positive experiences with substance abusing patients.

Suggestions to Overcome
Arrange simulated patient videos with patients programmed to provide easy cues, and who will readily agree if the physician suggests referral for treatment; attendance at AA meetings; faculty development meetings at inpatient treatment centers.

3C. Faculty preference for indirect suggestion rather than direct confrontation in substance abuse interviews.

Suggestions to Overcome
Provide instruction and simple confrontation techniques, demonstrate these in person or on videotape, and allow faculty to practice with simulated patients, providing appropriate positive feedback.

3D. Faculty discomfort in serving as experts in substance abuse conference.

Suggestion to Overcome
Provide faculty with videotapes and accompanying discussion guides for each conference.

HINTS AND NOTES TO THE INSTRUCTOR

1. Utilize local substance abuse treatment centers as teaching sites, and their personnel as co-teachers. Organizing a resident rotation can be tedious and time consuming, and staff in most good treatment centers are knowledgeable and more than eager to teach physicians.
2. Attempt to recruit key departmental personnel as faculty participants. (A) Behavioral Scientist. In our program, behavioral scientists are responsible for evaluation of simulated patient interviews with the resident and for conducting the session on substance abuse and the family. If these people are not knowledgeable in substance abuse, try to recruit them and provide them with faculty development opportunities early. (B) Chief Resident. In our setting, the Chief Resident did not receive instruction as a first-year resident, consequently he was sent for a one-week intensive training experience at a treatment center, and is now a strong supporter of the program. (C) Other Family Practice Faculty. Try to convince your department chair that without at least one or two other faculty persons involved, this effort will die at your institution when you leave, and convince him/her to ask for volunteers to join you in this effort.
3. Standardize simulated patients. Most of our drug patients were quite cooperative, some were quite passive, and others aggressive. Training will be easier if you let your simulated patients know exactly what you want, and perhaps even put them through a one- or two-hour training workshop where you demonstrate what you want through use of videotapes.
4. Allow residents to begin learning interview skills with "easy" simulated patients. Most residents have had only negative experience with patients who resist referral, and one or two experiences with simulated patients who agree to the treatment they recommend. Help motivate them to continue trying this with their own patients.
5. Allow for timely review of videotaped interviews. This is an element that needs to be planned into the schedule, in order to provide feedback to the resident as soon as possible after the experience.
6. Establish an exact schedule for group meetings. In our experience, telling residents to "attend one AA meeting sometime during the month" will often lead to procrastination.
7. Provide an active role for residents as care providers. Residents in an active teaching program are accustomed to bearing patient care responsibilities, and while they should be expected to do a significant amount of observing in the treatment setting, opportunities for histories, physical examinations, and management of detoxification make them feel like they are making a contribution and provide opportunities to apply skills learned.
8. Encourage frequent feedback with residents and other faculty members. A developing program needs this in order to eliminate nonproductive curriculum components and highlights the specific needs of trainees.
9. Expect various responses from residents based on their background and experiences. Two residents in our first year of operation showed little interest and some antagonism during the rotation; one of these was found to be the son of an actively drinking alcoholic.
10. Focus training on practical primary care skills, such as use of screening questions and tools for early diagnosis, hospital and office intervention approaches, detoxification skills. Be careful that your training program meets the needs of a primary care physician, and not a substance abuse treatment counselor.
11. Reinforce your teaching by bringing in outside experts. This helps validate the message you are trying to communicate as a teacher.
12. Consider utilizing a service contract to motivate your department and other faculty. Many treatment programs are looking for physicians or departments who will provide medical evaluations for their patients. The income generated may motivate your department chair to implement a combined service and training program, and will force involvement of other faculty, who will thus be stimulated to upgrade their knowledge and skills in substance abuse.
13. Seek the support of your department chair and residency director, as they hold the keys to your time utilization and to granting of curriculum time.

APPENDIX A

Substance Abuse Manual for Family Practice Residents

Department of Family Practice

Week 1: Overcoming Barriers to Effective Diagnosis and Treatment of Alcohol and Drug Abuse Patients

Clark WD, "Alcoholism: Blocks to Diagnosis and Treatment." *Am J Med* 1981; 71:275-286.

West LJ, Maxwell DS, et al., "Alcoholism." *Ann Int Med* 1984; 100:405-416.

Leckman AL, Umland BE, et al., "Prevalance of Alcoholism in a Family Practice Center." *J Fam Pract* 1984; 6:857-870.

Week 2: Early Diagnosis Intervention in Alcoholic Patients

Bush B, Shaw S, et al., "Screening for Alcohol Abuse Using the CAGE Questionnaire." *Am J Med* 1987; 82:231-235.

Skinner HA, Holt S, et al., "Early Identification of Alcoholic Use: Critical Issues and Psychosocial Indicators for a Composite Index." *CMA Journal* 1981; 124:1141-1152.

Michigan Alcoholism Screening Test (MAST).

Alcoholism: What are we missing? Recent developments in diagnosis and treatment of alcoholic patients. J Paul Seale, M.D., The University of Texas Health Science Center at San Antonio, San Antonio, TX, 78284, March, 1988.

Week 3: Family Aspects of Alcoholism and Other Drug Dependencies

DiCicco L, Underberg H, et al., "Confronting Denial: An Alcoholism Intervention Strategy." *Psychiatric Annals* 1978; 8:596-606.

Mooney AJ, "Family Aspects of Alcoholism and Other Drug Dependencies." In Wilford BB, ed., *Review Course Syllabus, American Medical Society on Alcoholism and Other Drug Dependencies*. New York: American Medical Society on Alcoholism and Other Drug Dependencies, 1987.

Blume SB, "Women and Alcohol: A review." *JAMA* 1986; 256:1467-1470.

Week 4: Alcohol and Drug Detoxification Use of Disulfiram and Naltrexone

Fleming M, Hunt V, "Alcohol Detoxification Protocol," University of Wisconsin, School of Medicine, Madison, Wisconsin, June 30, 1987.

Sellers EM, Kalant H, "Alcohol Intoxication and Withdrawal." *N Engl J Med* 1976; 294:757-761.

Pollack. University of Wisconsin Hospital and Clinics, "Alcohol Withdrawal Severity Assessment," University of Wisconsin, Madison, Wisconsin, 1987 (adapted).

Sellers EM, Naranjo CA, et al., "Diazepam Loading: Simplified Treatment of Alcohol Withdrawal." *Clin Pharma Ther* 1983; 34:822-826.

Kraus ML, Gottiel LD, et al., "Randomized Clinical Trial of Atenolol in Patients with Alcohol Withdrawal." *N Engl J Med* 1985; 313:218-222.

"Treatment of Acute Drug Abuse Reactions." Medical Letter on Drug and Therapeutics 1987; 29:83-86.

"Disulfiram Treatment of Alcoholism." Medical Letter on Drugs and Therapeutics 1980; 22:287-287.

"Trexan (Naltrexone Hydrochloride)." In *Physicians Desk Reference* 40th edition, New York: Medical Economics Company, 1986, 863-864.

Week 5: Drugs of Abuse Other Than Alcohol: Inhalants, Marijuana, and Cocaine

Nicholi AM, "The Inhalants: An Overview." *Psychosomatic* 1983; 24:914-921.

Fortenberry JD, "Gasoline Sniffing." *Am J Med* 1985; 79:740-744.

Schwartz RH, "Marijuana: An overview." *Ped Cl N Amer* 1987; 34:305-317.

Smith DE, "Cocaine-Alcohol Abuse: Epidemiological, Diagnostic and Treatment Considerations." *J Psychoactive Drugs* 1986; 18 117-129.

APPENDIX B

CASA VIDEO EVALUATION

I. CONFRONTATION

A. FOCUS 8 7 6 5 4 3 2 1

Clearly identifies presence of drinking problem	Displays uncertainty re diagnosis
Returns repeatedly to the issue of alcohol	Easily diverted to other issues
Provides evidence for diagnosis of alcohol abuse/dependence	Does not pick up on clues to diagnosis
Confronts the patients	Blunt, abrupt
	Rushes on/brushes over/skims past mention of diagnosis
	Minimizes the significance of early clues of alcoholism
	Does not clearly identify patient's behavior as problem drinking
	Refers only to "drinking a little too much"

B. FEELING 8 7 6 5 4 3 2 1

Communicates concern, warmth, caring	Communicates anger/hostility
Affirms patient's self-esteem/dignity	Exhibits closed/defensive body language
Makes offer(s) of personal support/availability	Condescending manner
Nonjudgemental	Detached, impersonal, lack of feeling
Makes physical contact with patient when appropriate	Rushed, hurried
	Uncomfortable distance from patient
	Communicates primarily on biomedical level
	Acts nervous

C. CONTROL 8 7 6 5 4 3 2 1

Physician	Patient

II. PATIENT EDUCATION

8 7 6 5 4 3 2 1

Clearly explains meaning of lab abnormalities	Uses medical jargon
Discusses long-term prognosis of illness	Offers lengthy differential diagnosis
Explains nature of compulsive drinking	Stutters and searches for words
Explains processes of tolerance and withdrawal	Uses word "alcoholism" inappropriately
Encourages feedback repeatedly	Displays uncertainty re diagnosis
Conveys hope re treatability	Conveys negative feelings re alcoholism
Defines abstinence as a goal	Disorganized in presentation
Identifies importance of outside assistance	Insensitive to patients' questions and concerns
Explains genetic nature of disease	Offers little information on the meaning of the diagnosis
Defines what physician means by "drinking problem"	Poor sense of direction
Clarifies likelihood that drinking and subsequent problems will escalate with time	Mentions "cutting back" as opposed to abstinence
	Does not differentiate between alcoholic drinking patterns and normal drinking patterns
	Provides misinformation
	Gives contradictory and/or ambiguous explanations

III. REFERRAL OR THERAPEUTIC TRIAL

A. REFERRAL 8 7 6 5 4 3 2 1

Clearly identifies referral agency	Offers multiple, confusing options
Offers to make contact for patient	Insensitive to patient's questions and concerns
Describes what treatment will involve	
Negotiates final plan with patient	
Involves family	
Makes follow-up appointment	
Discusses follow-up re both drinking and medical problems	
Makes provision for emergency help/change of plans	
Presents agency in positive light	
Explains referral procedure	
Makes sure patient understands procedure/expectations	
Considers possible need for detox	
Clearly defines short-term goals	
Defines long-term goals where appropriate	
Perseveres with an unacceptable option	
Speaks of "treatment" only in general terms	
Does not clarify what is expected of patient	

B. THERAPEUTIC TRIAL 8 7 6 5 4 3 2 1

Identifies treatment plan (AA meeting, controlled drinking, or abstinence)	Offers multiple, confusing options
Sets follow-up appointment	Insensitive to patient's questions and concerns
Makes sure patient understands procedure/expectations	Perseveres with an unacceptable option
Considers possible need for detox	Speaks of "treatment" only in general terms
Voices possible complications of this trial	Does not clarify what is expected
Makes provision for emergency help/change of plans	
Makes offer(s) of personal support or availability	

APPENDIX C

ALCOHOLISM AND DRUG ABUSE SURVEY

We are attempting to determine the approximate number of alcohol and drug abusing patients being seen by our residents, and where (if anywhere) these patients are being referred for assistance. You will be surveyed at the end of each month for the next year to attempt to establish a base line in this area. Please fill out this questionnaire and return to Ms. Imelda Garza, Family Practice Office, 4th Floor of the Brady/Green Clinic.

Month

Number of alcohol and/or drug abusing patients seen:

Number of attempted referrals to inpatient treatment centers:

Number of patients actually admitted to inpatient treatment centers:

If referred, please specify where:

Number of referrals to MHMR Detox Center (Crisis Stabilization Unit):

Number of referrals to VA Outpatient Alcoholism Clinic:

Number of referrals to Alcoholics Anonymous:
- Number of patients encouraged to attend:
- Number of times you called AA:
- Other (specify):

Number of referrals to Narcotics Anonymous:
- Number of patients encouraged to attend:
- Number of times you called NA:
- Other (specify):

Number of referrals made to other sites:

Please specify where:

Resident:

On what service were you during the month listed above?

APPENDIX D

EVALUATION OF THE CASA DEL SOL ROTATION

The objectives of the Casa del Sol rotation which you have just completed are to:

1. Recognize the existing barriers among physicians to effective treatment of alcohol and drug abusing patients.
2. Recognize early signs and symptoms of substance abuse and demonstrate appropriate history-taking skills in such patients.
3. Demonstrate skills in confronting, educating, and referring substance abusing patients encountered in various medical settings.
4. Recognize and manage the common medical complications of substance abuse, including alcohol and drug withdrawal.
5. Explain why substance abuse may be viewed as a family illness, and describe the implications for the family physician.
6. Describe the major components of an inpatient substance abuse treatment program.

Part I

In answering the following questions, please use the following scale as appropriate:

4 = Very Well; 3 = Well; 2 = Adequately; 1 = Poorly; or

4 = Very Good; 3 = Good; 2 = Adequate; 1 = Poor

Please answer all of the questions; we will use your experience to improve the rotation.

1. The statement of the objective is __________.
2. The relevance of the objective is __________.
3. The congruence between the objectives and your activities at Casa del Sol was __________.
4. The congruence between your attendance at meetings of a group of AA and the objectives was __________.
5. The congruence between the lecture-discussions you attended and the objectives was __________.
6. The continuity of the supervision you received at Casa del Sol from your attending was __________.
7. The congruence between the supervision you received at Casa del Sol and the objectives was __________.
8. The congruence between the Casa del Sol community meeting and the objectives was __________.
9. The congruence between the Casa del Sol evening group meeting and the objectives was __________.
10. The congruence between the simulated patient interviews and the objectives was __________.
11. The congruence between the materials you were required to read and the objectives was __________.
12. The evaluative feedback you received from your attending during the rotation was __________.
13. The congruence of the final evaluation with the objectives of the rotation was __________.

Part II

What parts of the rotation did you find most valuable?

____

____

____

____

What parts of the rotation did you find least valuable?

____

____

____

What do you feel should be added to or eliminated from this rotation?

____

____

____

____

What other comments can you make?

____

____

____

APPENDIX E

ORIENTATION FOR SIMULATED PATIENTS

Thank you for your interest in helping with the education and training of family practice residents and students. Each month, we are hoping to videotape a resident/student/physician doing two interviews with simulated patients in order to allow them to practice and develop their interviewing skills with substance abuse patients. We are asking you, as a recovering patient, to consider becoming involved as a simulated patient, to be interviewed no more than once a month. The situation we are trying to reproduce for the residents is a common one: an interview with a patient whose primary problem is substance abuse, but who visits the physician asking for help for some physical or emotional symptom, rather than the underlying chemical dependency. Your job as a simulated patient is to select a symptom, preferably one which you actually experienced during a time of substance abuse, and to perform in the interview as you would have under those circumstances. Please take a moment to reflect about things you saw a physician for at such times, and write two or three such complaints in the blank below.

We will review your complaints with you, and hope to pick one which may alert the resident to a possible substance abuse problem.

During the interview, we ask you to give realistic answers related to the complaint which you described to the physician. You may use your own personal medical history if you like, but this is not necessary. In addition, we ask you to make the following points:

1. When the physician asks how much you drink, give evasive answers which indicate that you do drink some, but you are unwilling to specify exactly how much.
2. Answer "yes" to at least two of the following so-called CAGE questions:
   A. Have you ever felt a need to cut-back on your drinking?
   B. Have you ever been annoyed by others criticizing your drinking?
   C. Have you ever felt guilty about your drinking?
   D. Have you ever taken a morning eye-opener?
3. If the physician should encourage you to get involved with Alcoholics Anonymous or some other treatment program, please be somewhat resistant initially, but allow yourself to be convinced if the physician persists.
4. Be prepared to give the resident some feedback at the end of the session. We try to weight the feedback heavily toward the positive, as this is an intimidating situation for theresident, and we would ask you to make mostly affirming comments. At the conclusion, you might offer one constructive suggestion to the resident/student for future interviews.

APPENDIX F

SIMULATED PATIENT INTERVIEWS

First Session: (15 minutes) This patient presents to you with a primary care complaint during a routine clinic session. You have been alerted by comments from other clinic staff that the patient may have a substance abuse problem. Take a history on the patient's chief complaint and, in context, ask whatever questions you feel are appropriate regarding substance use/abuse. Tell the patient you would like to do some laboratory tests and see him/her again in two days. At the end of the interview, leave the room. Draw CBC, SMA20, GGT, and anything else you like.

Second Session: (15 minutes) Your patient returns with chief complaint unchanged. CBC and SMA are within normal limits except the MCV, which is 100 (normal 82-98). The GGT is 75 (normal 7-56). Make whatever intervention you feel is appropriate for this patient.

Casa Del Sol

Rafael Martinez, M.D.

September 1988

S	M	T	W	T	F	S
				1	2	3
4 Community Mtg Casa-6:30-8:30p	5	6 1:30p--Staffing	7 8:30a--SA Conf 10:30a--Casa	8	9	10
11 Atend AA Mtg this wk/contact Dr. Armstrong 696-5451	12	13 1:30p--Staffing	14 8:30a--SA Conf 10:30a--Casa	15	16	17
18	19	20 1:30p--Staffing 6:30-8:30p--Casa Grp Mtg	21 8:30a--SA Conf 10:30a--Casa	22	23	24
25	26	27 1:30p--Staffing	28 8:00a--Eval 9:00a--SA Conf 10:30a--Casa	29	30	

8:30a--Substance Abuse Conference (SA Conf), every Wednesday, 4th Floor Conference Room, B/G
8:00a--Evaluation session, last Wednesday of month

Lorne R. Campbell, Sr., MD

A One-Week Packaged Flexible Module for Family Practice Residents

CONTENTS

Page
Curriculum Example Description 67

Appendices:

Chemical Dependency: A One Week Experience, Instructors Manual 70

Lorne R. Campbell, Sr., MD
Serenity Recovery Center
232 West 25 Street
Erie, PA 16544
(814) 452-5556

A ONE-WEEK PACKAGED FLEXIBLE MODULE FOR FAMILY PRACTICE RESIDENTS

CONTEXT

Setting

This program was initially designed for a university affiliated residency program, however, the setting is of only minor concern. The program is flexible enough to be used in any setting with only minimal changes to the program

Level of Participants

First-year family practice residents

Contact Time

Six half-days

Tie into Overall Curriculum

This program is a block of flexibly interchangeable modules, and its integrity needs to be maintained over a short duration of time

RATIONALE

It is difficult to accomplish a great number of goals in a short period of time. However, this program focuses on providing a maximum amount of information, skills, and knowledge in a condensed fashion. We have targeted five basic areas of difficulty in teaching substance abuse. These include:

1. Family practice preceptors don't model the behavior of intervention with alcoholics
2. Preconceived notions attained through medical school make for negative professional feelings toward substance abusers
3. There is a common misconception among family practice residents that nothing can be done with alcoholics
4. Family practice residents wouldn't know what to do with an alcoholic if one walked in and said, "I have a problem, and I need help."
5. Residents' individual backgrounds and family problems with substance abuse will interfere with their ability to acquire the knowledge, skills, and attitudes necessary to be successful when handling substance abusing patients

OBJECTIVES

Knowledge

1. Residents will have an understanding of basic concepts of substance abuse, including an idea of common attitudes, helpful and not helpful, in dealing with substance abusing patients; basic theory and knowledge of interviewing techniques; information regarding the diagnosis of substance abuse and screening instruments; knowledge of the CAGE and MAST screening instruments specifically; knowledge of intervention; how to manage withdrawal; treatment paradigms and facilities; knowledge of the family's role in substance abuse; and, information about family physicians at risk
2. Residents will have knowledge of how their own attitudes interfere with making the diagnosis of substance abuse or in dealing with addicted patients; knowledge of at least three types of interventional strategies, including minimal intervention, how to discuss substance abuse with a patient, and the method of Johnson intervention
3. An idea of how to manage a crisis

Skills

1. Resident will be able to demonstrate the ability to obtain an alcohol history, to take an alcohol history, and discuss alcohol use on a role-playing patient
2. Will be able to demonstrate one technique for linkage
3. Will be able to use that technique of picking up a phone and calling the treatment facility, asking for a treatment person, introducing self, and then handing the phone over to the client to ensure that linkage is made

Attitudes

1. The resident should be able to demonstrate the appropriate attitude necessary for successfully working with alcoholic patients
2. Any residents who have difficulty with severe negative attitudes or severe problems during the week will be allowed assistance, and their negative attitudes or difficulties with the week will be dealt with

INSTRUCTIONAL STRATEGIES AND ACTIVITY SEQUENCE

Day One

Morning: During the first half of day one, the resident will be given an overview of the course, will be given materials, and logistical aspects of the course will be described. The resident will meet with the physician to do this. This will take approximately one-half hour. The next hour will be spent with the course coordinator discussing history taking in an interactive way. The following hour, the resident will spend ingroup therapy with clients in early recovery from alcohol. The resident will learn defense mechanisms and get a first-hand observation of people in the early struggles of recovery

Afternoon: One hour of the afternoon is devoted to discussions surrounding how to get a patient into treatment, what a family physician needs to know about treatment and what to tell patients about treatment, with a lot of emphasis on the fact that treatment is successful and true prognosis statements. The remainder of the afternoon is devoted to viewing the Alcohol and the Physician videotapes, selected readings, time to process what has happened, and free time. At the end of the day, the resident meets with the faculty preceptor to discuss his/her feelings about the day

Day Two:

Morning: In the first hour, the resident will meet with MD faculty to discuss MD intervention, which entails three types:

1. A minimal intervention of challenging the patient with substance abuse as being the cause of problems
2. Information regarding a more formal Johnson Intervention
3. Instructions on how to use crisis situations to motivate patients into treatment

Also during this session, in the second half-hour, a genogram will be completed on the resident. This will serve two purposes:

1. It will identify any potential difficulties the resident has in his/her own family background in dealing with substance abusing patients
2. It will demonstrate the power and utility of obtaining a family history by using a genogram technique. Information about the resident's own risk for substance abuse will be discussed at this time

The remainder of the morning is time unplanned so the resident can process, read, or watch videos

Afternoon: The resident will meet with the faculty including the MD who will be the character in the role play (see example of standard character). This takes approximately 15-20 minutes. Immediately following this is a one-hour session to process the events of the role play. Here, the resident's strengths are accentuated and rewards are given to the resident for satisfactory accomplishment of goals and objectives of a successful interview. Areas needing improvement are usually brought up by the residents, and these are dealt with as strengths as well. In other words, the resident is rewarded for the ability to identify areas where he/she needs improvement. The remainder of the afternoon is free time

Day Three:

Morning: The resident starts two hours later than normal, and only attends an upper level therapy group with patients who are well into recovery and almost finished with the program. This facilitates the resident's understanding of someone with a good deal of recovery under his/her belt, in order to contrast what was seen in the previous session

Afternoon: The remainder of the afternoon is free time, with time to meet with the preceptor to discuss any issues or questions. The preceptor keeps this time free, however, it is voluntary for the resident to attend. Residents usually attend

Evening: The resident is met by an A.A. member, a male member escorts male residents to meetings and a female member escorts female residents to meetings. This takes approximately two hours, considering a half-hour travel time each way. This has proven to be one of the most powerful experiences of the week. The resident is then debriefed sometime during the last day of the week, which is a clinic day. Time is kept in the schedule to debrief and find out the resident's impressions of the whole course

INSTRUCTIONAL MATERIALS AND STRATEGIES

Materials

1. A manual of selected readings
2. An instructional guidebook to highlight particular points of the course and to act as a carry-away from the course for the resident's future reference
3. A fairly comprehensive bibliography
4. Alcohol and the Physician Parts I-IV. 1) Attitudes; 2) Early Diagnosis; 3) Confirming the Diagnosis; 4) Physician's Role. Hazelden Educational Materials; Box 176; Center City, MN 55012
5. "Our Brother's Keeper," Hazeldon Educational Materials, Box 176; Center City, MN 55012
6. A standard character chart, the character's name is Paul Green

Instructional Strategies

1. Individual sessions with:
   A. MD faculty
   B. Behavioral science faculty
   C. Program director
2. Attendance at two group therapy sessions in an actual working clinic
3. A session with the doctor to go over the resident's own genogram to look for blocks the resident may have in dealing with alcoholic patients, one of the most powerful blocks being the resident's own family background
4. The participation in a role play with the faculty preceptor
5. Whenever possible, the attendance of the resident in a session with the faculty preceptor who takes a substance abuse history on an early client in substance abuse treatment center. This is done in the context of an admission physical examination
6. Sponsored attendance at an open A.A. meeting

SPECIFIC RECOMMENDATIONS FOR IMPLEMENTATION AND MANAGEMENT

1. The administration of this program is fairly simple in that all the modules are interchangeable within certain specific guidelines. The session where the family history is gathered from the resident needs to be done somewhere in the middle of the week to allow time to observe the resident for problems
2. Administratively, this program is available on computer disk. This is a computer disk we will generate with all reminders to residents and all participants that the resident will be participating during the week and what is expected of everyone. This allows for a minimum of organizational time in setting up the course
3. It's crucial to have an A.A. member sponsor the resident to an A.A. meeting. This will alleviate a lot of the resident's discomfort at walking into a meeting. One of the most threatening parts of the week was the attendance at the meeting. However, once the residents got into the meeting, they then felt extremely comfortable
4. It is important to have faculty contact somewhere during each day to allow the resident to ask questions, vent frustration, and a chance to observe the resident to see if there are any problems that come up during the week's attendance
5. Communication networks need to be set up so that absenteeism from any point can be investigated. The usual causes for absenteeism we have found are:
   A. The resident actually had a legitimate reason for not attending a group session
   B. The resident had extreme difficulty with the topic

INSTRUCTIONAL MATERIALS AND RESOURCES

Readings

Overview:

Cooley, F. B., "Alcohol and Drug Abuse in an Urban Environment." *Urban Family Medicine*, Chapter 13, 1987

Attitudes:

Chappel, J.N., "Attitudinal Barriers to Physician Involve- ment with Drug Abusers." JAMA, May 14, 1973

Lieber. *An Intern's Lament*, 1971

Interviewing:

Weinberg. R.R. "Interview Techniques for Diagnosing Alcoholism." *American Family Physician*, March 1974

Diagnosis:

Symptoms of Substance Abuse - Desk Reference on Drug Misuse and Abuse. The Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, Canada M55231

Intervention:

Liepman, M.R., Fisher, J.V., Whitfield, C.L. "Motivating Change." *Family Medicine Curriculum Guide to Substance Abuse*, Chapter 4. STFM 1984

Johnson, V.L. "The Dynamics of Intervention." *I'll Quit Tomorrow*, Chapter 6

Withdrawal:

Medical Complications of Alcoholism. World Health Organization (1983). *Alcohol Consumption and Alcohol-related Problems: Development of National Policy and Programs*. Technical Report 35, Geneva

Holloway, H.C., et al. "Recognition and Treatment of Acute Alcohol Withdrawal Syndromes." *Psychiatric Clinics of North America*, Vol. 7, #4, December 1984

Treatment:

Skinner, H.A., et al. "The Early Identification of Alcohol Abuse." *Basic Strategy for Treating Alcohol Abuse.*"

Cooley, F.B. *Treatment Flowchart*. Unpublished

Anderson, R.C. et al. "Treatment Planning and Referral." *Family Medicine Curriculum Guide to Substance Abuse*, Chapter 6. STFM, 1984

A Checklist of Symptoms Leading to Relapse

Family:

Anderson, R.C., Liepman, M.R. "Chemical Dependency and The Family." *Family Medicine Curriculum Guide to Substance Abuse*. STFM, 1984

Physician:

Fisher, J.V. et al. "The Family Physician at Risk." *Family Medicine Curriculum Guide to Substance Abuse*, Chapter 9. STFM, 1984

MATERIALS DEVELOPED SPECIFICALLY FOR THIS COMPONENT

Campbell, L.R. *Curriculum Guide to Accompany Course for Resident Participants*. Unpublished

Campbell, L.R. *Instructor's Manual for Curriculum Guide to Accompany Course*. See appendix

Audiovisual Aids:

1. Alcohol and the Physician Parts I-IV (Attitudes, Early Diagnosis, Confirming the Diagnosis, Physician's Role), Hazelden Educational Materials. Box 176, Center City, MN 55012
2. Our Brother's Keeper, Hazelden Educational Materials; Box 176; Center City, MN 55012; 1-800-328-9000

Faculty Instructors:

1. Behavioral science member—1
2. Family physician faculty—1
3. Director of operating clinic—1
4. Family therapy, alcohol/drug unit—1

Resources:

Operating alcohol/drug clinic

EVALUATION STRATEGIES

Strategies:

1. Pre- and Post-Substance Abuse Attitude Surveys
2. Quick Test for Alcoholism Knowledge
3. Outside Evaluator for Role Play Videotapes

Organizational Constraints:

Constraints	Suggestions to Overcome
1. Lack of faculty role models.	1. Educational guidebook and participation in experience
2. Obtaining curricular time.	2. Carve time out of electives with minimal interest or poor evaluations

APPENDIX

Chemical Dependency: A One-Week Experience

INSTRUCTOR'S MANUAL

Lorne R. Campbell, Sr., MD

This is a one-week modular experience in chemical dependency. The experience has three goals. These are to provide the knowledge, skills, and attitudes necessary for family physicians to deal with patients who are chemically dependent. The modular system is geared to maximize the three goals using a minimum amount of time and personnel.

Materials for this course include videotapes, selected readings, and a bibliography for further reference. To efficiently use residents' time, about one-half of the course is independent study. The other portion is divided between selected contact personnel to discuss various aspects of chemical dependency.

Residents should find this course interesting, informative, and enjoyable.

Segments of the week require mandated attendance. This requires a minimal amount of scheduling.

The modules are designed to fit around a given resident's relatively fixed schedule. Pieces of the schedule are fit into place after the determination of the resident's office schedule. (See example 1).

The components needing adjustment include:

1. An introductory module—approximately 1-2 hours
2. An intake screening session—1-2 hours
3. Discussion of 2 hours; screening instruments, completing of genograms, MAST, and role play of early assessment.
4. Attendance at family group—2 hours
5. Participation in a treatment group—2 hours
6. Discussion of interventions and defense mechanisms—2 hours
7. Sponsored attendance at an open AA meeting—2 hours
8. Final meeting for discussion-1 hour

This course will be best received if portions of it are taught by a physician. The discussion of assessment, the course introduction, and the final wrap up modules probably carry much influence.

Segments can be added, subtracted, or altered to meet particular demands. Some of the underlying successes appear to be contingent upon contact with recovering alcoholics. Basically, the more contact with recovering alcoholics, the better the experience. When changes are made, this axiom should be kept in mind.

This manual details each component of the week and reviews course materials. It is set up to facilitate instruction of this course, and most information to teach this course can be found in this manual.

TABLE OF CONTENTS

Attitudinal Segment 71

Attitudinal Barrier to Physician Involvement With Drug Abusers Review of Cork I

Interviewing 71

Interviewing Techniques for Diagnosing Alcoholism; Weinberg *Screening for Risk Factors of Adolescent Alcohol and Drug Use Michigan Alcohol Screening Test*

Diagnosis 71

The Early Identification of Alcohol Abuse, Skinner
Symptoms of Substance Abuse Course and Stages of Alcoholism

Intervention—Motivating Change 72

Treatment 74

ATTITUDES

Discussion: 1. There is no stereotypical chemically dependent person. The down and out drunk represents less than 5% of all drug or alcohol abusers.

2. Physician attitudes toward chemical usage can help a chemically dependent patient seek attention. Conversely a different attitude can reinforce the patient's problem or can be construed as permission to continue using. A negative attitude can cause the patient to respond with intense defenses, thwarting all attempts to obtain help.

Materials:

Video: Part 1. Deals with physicians attitudes. The video takes a physician through his/her experiences with alcohol while growing up. Next, the video explores attitudes toward diagnosing. The resident should be presented this material early in the experience. Optimally, discussion of this material should be covered in the diagnostic section. Attention should be paid to the residents' own attitudes. Problems of issues within the residents' lives may surface at this point.

Attitudinal Barriers to Physician Involvement With Drug Abusers. Chappel deals with physician attitudes globally.

INTERVIEWING

This section of the course discusses supportive history gathering

Discussion: 1. Relationship building. A family physician's strongest tool is his/her relationship with the patient and family. By establishing the patient's and family's trust and confidence, the physician obtains a good position to help effect change. The relationship between the patient, the doctor, and the effect of his/her defenses needs to be constantly monitored. If the patient's emotional threat becomes too great, the defenses become more pronounced. At a point, the defenses become so influential that the relationship is jeopardized. Effective use of the relationship and monitoring of patient defense mechanisms can reduce anxiety and facilitate the patient and family to seek assistance for chemical dependency problems.

2. Remaining supportive. It is extremely difficult to maintain a supportive attitude with a difficult patient early in sobriety who has multiple relapses. It is also difficult to be supportive to patients with strong defense mechanisms.

3. Observing behavior. Not only is what is said important; often information not said or physical body language is revealing of a problem.

4. Understand defense mechanisms. Chemically dependent patients have strong defense mechanisms. The four main types would include:

   A. Denial. The patient cannot comprehend that the chemical of choice causes any adverse effects, let alone consider it the main problem.

   B. Rationalization. Statements such as "Everyone drinks," "All of my friends smoke pot," "I drink to be sociable," or "You would drink, too, if you had my problems," are rationalizations. These explanations in the mind of the abuser are to justify the drinking or to justify the problem.

   C. Minimalization. "I only drink a couple," "I can quit any time I want," "I only drink beer" are some examples.

   D. Intellectualization. "Drug abusers useneedles, I only smoke crack," "Marijuana has never been proven to be addictive."

Materials:

Video: Part 2 Covers diagnosis and discussions of chemical use with patients.

Articles: Interview Techniques for Diagnosing Alcoholism. J.R. Weinberg. A useful how-to article dealing with attitudes and nonjudgmental directions.

DIAGNOSIS

Resident's Manual:

History Understanding the progressive nature of the illness and staging becomes essential to the recognition and diagnosis of chemical dependency. It is necessary to develop an alert attitude to jokes about chemical dependency or off-hand comments about job, family, or legal difficulties. These are early clues to chemical dependency problems. Few patients will ever present with a primary complaint of drinking too much. But many patients will present with problems that are a result of their chemical usage. Illnesses such as high blood pressure, anxiety, depression, gastrointestinal problems, or sexual dysfunction potentially are secondary to chemical use.

When evaluating problems with patients, chemical abuse should be included as a differential diagnosis, especially when problems such as injuries, medication overdoses (accidental as well as intentional), noncompliance, stress related problems, or problems with unexplained poor response.

During routine screening, the CAGE questionnaire is extremely useful. These four questions asked routinely yield much useful information. The CAGE questions revolve around problems rather than quantities. Although quantities are of some importance, assessment and therapy are geared around problems.

Have you	Cut down your drinking?
Do you become	Angry when people talk about your drinking?
Do you feel	Guilty about anything you did when you had been drinking?
Have you ever had an	Eye-opener?

Three to four positive answers are highly suspicious of an alcohol or chemical dependency problem. Two questions are suspicious of an alcohol problem and other questioning should occur. A positive answer to the cut down question itself should strongly raise suspicions of a chemical abuse problem.

Points to cover in a more comprehensive questioning can be guided by the acronym CHEMICALS:(2)

Essentials of Alcohol History

C Complications/consequences of use

H Help sought for those problems in the past and outcome of the help

E Enablers in the environment and their effect on the illness

M Maximum dose ever taken, minimum dose to have an effect

I Intake or ingestion details, drugs, routes, frequencies, sources, doses

C Concerns the person has had about this problem in the past, thoughts of changing

A Abstinence, with cessation, advantages of abstinence

L Losses if the person quits, disadvantages of abstinence

S Synergy, between alcohol/drugs, and other medications and illnesses

STAGING (1) Initially most chemical users fall into a pre-dependency relationship with chemicals. The relationship is casual and no commitment to ingestion is made. In other words, reasonable usage of the drug occurs. "Live and use" is the underlying concept of a pre-dependency stage. The length of time spent in a pre-dependency stage depends on the individual, the chemical used, and route of administration. With drugs such as alcohol or marijuana, the pre-dependency stage may be variable in length. The stage may last a short period or go on indefinitely. Type 2 alcoholics (male inherited), for example, probably pass through this stage rapidly. Others can remain in this stage for years and some never progress. For other drugs, such as cocaine and crack, or narcotics, this phase is generally extremely short in duration.

Chemical dependency progresses through four stages. The timing of progression occurs at different rates among different individuals. These stages can be understood by understanding the individual's relationship to the chemical.

The initial stage of dependency is based on a developing committed pathological relationship to a mood altering chemical in expectation of a rewarding experience. The predominate motivation is pleasure. These people look forward to and ingest the chemical with the expectation of pleasure. The person "abuses the chemical and lives." This relationship shows a blend of independence and interdependence.

Next is the chronic stage, during which the user knows what the chemical can do. At this stage he/she uses it on new or experimental occasions or to remedy situations, stress, or emotional upsets. Use of the drug as relief or "live to abuse" are the predominant motives of this stage.

The third acute stage is characterized by "abuse to live." The user needs to use the drug to maintain minimal levels of function. The user maintains a chemically dependent state as the normal state.

The predominant motivation of the terminal stage is the escape to oblivion, or the escape of withdrawal. This is the escape from total dysfunction by constant intoxication and finally death. Here the key concept can be interpreted as "abuse to die."

Progression through these stages is not a linear progression. Graphically it would be demonstrated as a sawtooth with ups and downs, but the overall trend is toward more severe.

Discussion:

1. The diagnosis of chemical dependency can be fairly straightforward if a high index of suspicion is maintained. A high index of suspicion, attention to behavioral mannerisms, and a nonjudgmental, open attitude are beneficial in the diagnosis of chemical dependency problems.
2. The diagnosis needs to be shared with the patient, however, not necessarily at the time that it is made. Timing of presentation is vital. A patient who is confronted with the diagnosis too early may become defensive and leave. On the other hand, waiting too long builds family anxiety and may precipitate a change of provider.
3. Quantities of drugs or alcohol are only secondarily important. More pertinent and clinically useful are the effects that alcohol has on the patient, his/her family, or his/her job.

Materials:

Video: Part 3 Deals with diagnosis of alcoholism and intervention in the process of alcoholism.

Literature: *Early Identification of Alcohol Abuse*. M.A Skinner, et al. Practical guidelines for signs and symptoms of alcohol abuse.

Symptoms of Substance Abuse. Reference guide for commonly abused drugs

The Course of Alcoholism covers alcoholism as a progressively worsening illness. Three stages are presented.

INTERVENTION— MOTIVATING CHANGE

Motivating Change

As done with other illnesses, the family physician needs to be able to match the therapy to the illness. A patient in early stages of chemical dependency needs a different approach than does a patient in a later stage.

Permission to discuss the patient's problem with the patient is important to obtain. A patient who presents with gastritis, hypertension, and insomnia is probably not ready to allow you to discuss chemical abuse as a cause. If you center your talk around the presenting complaints, while attempting to educate the patient with linkages between the substance and the symptoms, frequently you can obtain the permission to discuss the chemical problem.

Normalizing the patient's problems helps the patient feel more comfortable in disclosing information. Positive feedback and clarification are extremely useful tools to taking a relationship past a potential defense mechanism.

Titrating the relationship is a concept to bear in mind when discussing abuse problems. Close monitoring of the balance of the doctor/patient relationship and patient's defense mechanisms is important. Topics can be discussed on varying levels of comfort from both the physician's and patient's standpoints. A shift to a more comfortable level is necessary when a question is asked and provokes extreme discomfort in the patient. The practitioner needs to continue at that level until the patient is comfortable with that level of discussion. Then the next level can be tried again. Careful support must be offered the patient when examining the areas of recognized problems.

Obtaining allies within the patient's family is a profitable and rapid method of getting a patient past a defensive hang-up point. The patient working in concert with the family to solve ulcer, hypertension, and drinking problems is much more valuable than an uninvolved family.

As with other illnesses, the family physician needs to correctly match the level of therapy to the severity of illness. A patient in early stages of chemical dependency needs to be approached differently than does an end stage alcoholic. Staging becomes crucial to the selection of the appropriate intervention strategy.

In the presymptomatic stage, warnings about risk factors, such as family history or stress reduction, may be of some benefit. Teenagers or young adults would be the best targets of this type of intervention. Waiting, supporting, and development of a strong doctor/patient relationship are powerful tools which will have an impact later on.

Early in a chemical dependency problem the physician has time as an ally. At this point, careful follow-up and low-key interventions are the best management tools. Maintenance of the doctor/patient relationship is key. If too strong an intervention is attempted early, the patient will be pushed away. If no attempts at intervention are made, however, the family will most certainly become frustrated and will be likely to seek care elsewhere. The patient may take the doctor's lack of action as an endorsement of drinking or a confirmation that the drinking is not problematic.

During the early stages of dependency, the decision to gently challenge and support is the best strategy. Here relationships and trust building are still the most powerful tools. The physician must constantly balance the relationship and the patient's defense mechanisms. Patients with suspected problems related to alcohol or other chemicals must be carefully handled using contact through follow-up and low-key interventions.

The best approach is to involve the family early in therapy. The patient's spouse, once involved, will become an important therapeutic ingredient. Ways of joining with the spouse to enlist the other family members include: Stick to presenting symptoms. Relate the reason for family consult back to the original symptoms. For example, a patient presented with a gastritis-type pain (secondary to alcohol abuse). During the interview it was explained that many factors are involved in the development and management of gastritis. The patient's wife prepared the food, so she would need to understand diet alterations and other management steps. This linking and explaining works well in incorporating other family members into therapy. With patients who are resistant or hesitant, occasionally permission to contact the family directly can be sought. Call with the patient present. Quite often it may take a series of two to three visits to have the patient's other family members join in therapy.

After the spouse and other family members are assembled, then prescriptions for management need to involve all members present. Further follow-up should involve the family. Discussions of successes with prescribed activities need to be discussed, and solutions to problems, especially noncompliance, need to be sought within the family group. The family strengths and resources need to be sought and brought to bear on all difficult areas of management. One of the toughest areas to manage is the chemical use of a chemically dependent patient. The involvement of family is essential to the solution of a problem of chemical dependency, as the ramifications of the problem are felt throughout the family.

The physician needs to take a deliberate, specific course to assist the patient and the family in accepting the primary diagnosis.

The following are some possible approaches to take.

Education:	Present information to the patient and family members to correct misinformation about chemical abuse.
Interrogation:	Ask patient to self-examine.
Declaration:	Linkage of complaints to the substance abuse. This can be used only with a firm relationship.
Normalization:	Explaining about other patients with the same problems. This allows the patient to feel that he/she is not alone with his/her problems or fears. Use terminology and mannerisms that indicate problems and difficulties as normal or usual. This will allow the patient to be more comfortable accepting problems and foster a better relationship.
Incremental Insight:	Allow the patient a little greater insight into the problem with each subsequent visit.
Self-Identification	Allow patient to view materials, attend meetings, fication:or meet people with satisfactory visualization of their problems.

Putting the Disease in Perspective: It is easy to focus on the negative aspects of a person's behavior. This, however, is most often counterproductive and very uncomfortable. On the other hand, supporting the things that are working well and supporting the patient to incorporate one or two new and small improvements will be much more beneficial. Identifying family strengths and allowing the family to use those to identify and solve problems will then empower the family to be self-therapeutic. These identified strengths can then outweigh the identified negatives to follow.

Utilizing Crisis: Utilizing crisis can prove an effective way of expediting change. If crisis can be linked directly to patients' drinking, then patients will frequently examine their drinking behavior. A crisis can be any situation. Marital problems, children, school problems, medical issues in the patient or other family members, DWIs, or legal problems. Conversely, if any crisis is brought to the family physician's attention, then inquiries around chemical usage need to be made.

Linkage: When a patient agrees to seek therapy, it is useful to have the designated program prepared in advance. If the choice is outpatient therapy, then ready access to the phone number is necessary. After the patient agrees to treatment, pick up the phone, call the program, speak to a counselor, explain some of the story, and then hand the phone to the client to talk with the counselor. By doing this fairly easy task, you have removed the patient's anxiety about calling. You will increase the chances that the patient will actually seek counselling.

Intervention in Late Stages: Finally, if a patient is an end stage alcoholic, a very powerful technique can be called upon. This technique was pioneered by Vernon Johnson and described in *I'll Quit Tomorrow*. The use of this model needs prior planning and coordination of all participants. The intervention needs to be rehearsed and orchestrated in advance. The way an intervention occurs is as follows.

The patient's family and other people influential to the patient are gathered without the patient. Lists of incidents when the drinker's drinking affected each person are prepared. Arrangements are made for a stay in an inpatient facility in the event intervention is successful. Each person needs to rehearse his/her own list and how possible responses will be countered. Definite actions that the family wants to occur are discussed. Ramifications and actions to be taken in case of failure are laid out. The entire intervention is rehearsed without the alcoholic. The alcoholic is then brought to the intervention without prior knowledge. Then the lists and expectations are shared in a caring but firm manner. This technique is very powerful for motivating a patient into treatment; occasionally failures do occur, and these must be handled.

After any of these techniques are successful and the alcoholic goes into treatment, the work begins. Support and attention must then be given to both the alcoholic and the family as well. Family members may wonder if they have done the appropriate thing. Issues will surface that need attention. The intervention may also reveal chemical dependency problems in other family members. And finally, changes must be made at home to prevent relapse after discharge.

Once the patient and the family are in agreement that the patient's symptoms are in some way connected to drinking, then multiple levels of interactions can be successful.

Discussion: The disease of chemical dependency occurs for a number of reasons. One of these reasons is a strong denial that a problem exists. It is necessary to work around this defense mechanism if change is to occur.

Intervention is the motivation of change in a chemically dependent patient's system that facilitates treatment seeking. Multiple models of interventions have been tried. The versatilefamily physician should be versed in a number of different approaches to intervention.

The articles in this section present a number of different models of intervention.

Materials:

Video: Part 3. Deals with an intervention in the case of a teenage boy involved with alcohol.

Articles: *Motivating Change*. Fisher, J.V., Liepman, M.R. Family Medicine Curriculum Guide to Substance Abuse. STFM 1984

Treatment

Treatment of chemical dependencies is broken into three components: assessment, detoxification, and supportive therapy

Assessment:

Chemically dependent patients potentially have many medical complications as a result of their chemical use. Some of the most common medical complications of alcohol dependencies include overhydration, coarse tremors, hypertension, autonomic nervous system instability, anxiety, insomnia, increased pains, multiple somatic complaints, liver disorders, macrocytic anemia, cardiac problems, and multiple injuries.

Convulsions and DTs occur in about 5% of patients during withdrawal.

Detoxification Management:

Rest

Vitamins: Thiamine 100 mg, 1 mg for 3 days
Folote 1 mg po daily for 3 days
Multiple vitamins

Diet: Unrestricted diet, adequate amounts and well-balanced.

Fluids: No IVs, as patients are usually overhydrated. Allow unrestricted fluids by mouth.

Chemotherapy: Cross tolerant depressant drugs, such as Valium, Librium, or Phenobarbital, in quantities sufficient to minimize withdrawal symptoms, followed by decreasing dosages over four or five days.

Other Medications: Continue other non-psychoactive medications as necessary. Consider stoppage of antihypertensive medications with close monitoring of vital signs.

Support Therapy: Discussions and caring to deal with patients' Therapy:anxiety, paranoia, depression, shame, and anger need to be conducted by trained counselors. Smooth linkage and referral to appropriate aftercare are important parts of everyone's functioning.

After detoxification, patients need treatment in inpatient or outpatient centers.

Inpatient treatment usually lasts 21-28 days and is usually comprised of a mixture of groups and individual therapy sessions. Most programs include AA participation either on site or nearby. Family therapy is an important component to most good programs. Patients who require inpatient treatment are those with severe problems, no support systems, or who have failed outpatient treatments. After completion of an inpatient stay, most patients go on to an outpatient program. Linkage is important here as well. Poor linkage to an outpatient program usually results in less than optimal care and frequent relapse.

Outpatient treatment is for those patients with early disease, good support systems, or who have completed inpatient therapy. Therapy includes about six to nine months of weekly sessions. The format is usually group therapy, and the most successful programs include family therapy as well.

Materials:

Articles: *Recognition and Treatment of Acute Alcohol Withdrawal Syndromes*. Halloway, H.C., Psychiatric Clinics of North America, Dec. 1984.

Basic Strategy for Treating Alcohol Abuse.

Treatment Flowchart. Cooley, F.C., Bothelo, R.C.

Treatment Planning and Referral. Anderson, et al. Curriculum on Substance Abuse for Family Practice

Families

Discussion: Chemical dependency affects all members of the patient's family and other people associated with the family. It is necessary to ensure that all members of the family receive information and counselling regarding the impact on them, as well as the functioning of the family.

Materials:

Articles: *Chemical Dependency and the Family*. Anderson, R.C., Liepman, M.R., Family Medicine Curriculum Guide to Substance Abuse. STFM 1984

Protocols: Chemical Dependency and the Family. Doherty, W., Baird, M.A. *Family Systems Medicine*, Summer 1985

IMPAIRED PHYSICIANS

Discussion: Physicians have the same risk for alcoholism, but a 300-times greater risk of substance abuse than the general population. Reasons for physiciansubstance abuse include unfulfilled expectations, stress, physical disability, and clinical errors, among others. Physicians need to be aware of the risk among other physicians as well as within themselves.

Materials: *The Family Physician at Risk*. Fisher, J.V., et al. Family Medicine Curriculum Guide to Substance Abuse. STFM 1984

ROLE PLAY

Role playing is beneficial when teaching the skills necessary to interviewing chemically dependent people. A properly chosen character model can be helpful in alleviating fears the interviewer may have about discussing chemical dependency with patients.

The best character to use is one who gives multiple clues and is willing to listen to the diagnosis and therapy plan. The patient should put up some resistance, but not too strong. This may be the first time the interviewer has discussed chemical dependency with any patient.

The character provided here is an example of a patient with an early chemical dependency problem. Multiple diagnostic clues have been gathered by a previous interviewer; however, the common thread of an alcohol problem has not been seen. This is the patient's second interview, and it will be the patient's first interview with the interviewer.

Following the role play, feedback to the interviewer should be given. This can be enhanced if the role play is videotaped, then reviewed with the character and preceptor present. Positive feedback at this stage is extremely important to ensure that the interviewer retains the newly learned concepts.

James Finch, MD

A Curriculum in Substance Abuse for Family Practice Faculty

CONTENTS

Page
Curriculum Example Description 77
Appendices:
Alcohol and Drug Abuse: A Functional Response for the Primary Care Physician 81
Case Discussion 82
Post-test 83
Personal Assessment 84

69

James Finch, MD
Department of Community and Family Medicine
Duke University Medical Center
407 Crutchfield St
Durham, NC 27704
(919) 471-4421

A CURRICULUM IN SUBSTANCE ABUSE FOR FAMILY PRACTICE FACULTY

CONTEXT

Setting

Family practice residency program--university

Level of Participants

Family practice faculty

Contact Time

Seven hours (exclusive of assignments)

How Tied into Overall Curriculum

Independent of residents' curriculum

Scope of Substances Covered

Alcohol and other drugs of abuse

RATIONALE

The overall goal of the curriculum is to improve the substance abuse attitudes, knowledge, and skills of all the faculty members of the division of family medicine, and thereby involve them in substance abuse teaching on a regular basis.

OBJECTIVES

Knowledge

1. Be able to define an appropriate role (expectations and limitations for family physicians dealing with chemical dependency in their patients).
2. Be able to define high-risk drinking behavior and provide preventive counseling against alcohol abuse.
3. Know the elements of treatment for chemical dependency, how to identify the treatment appropriate to each patient, and the role of self-help groups in treatment.
4. Know how to diagnose and treat withdrawal syndromes for common drugs of abuse, including indications for inpatient and/or pharmacologic treatment.
5. Be able to outline an approach to involve the family of the dependent patient in the diagnosis and treatment process and know the treatment resources available for family members.
6. Know the signs and symptoms of physician substance abuse, and know the steps involved in seeking help for oneself or other clinicians.

Skills

1. Be able to apply methods of screening or otherwise identifying dependent patients within the clinical setting.
2. Be able to use patient interview and confrontation to diagnose and initiate treatment for chemical dependency, as well as foster compliance with treatment.
3. Be able to apply knowledge and skills regarding chemical dependency to one-on-one teaching encounters with resident learners.

Attitudes

1. Understand the impact of chemical dependency on the health care of this country, and acknowledge the importance of family physician involvement in diagnosing and teaching about this treatable disorder.
2. Recognize the importance of attention to the family of the dependent patient.
3. Recognize the importance of attention to the physician's own risk for chemical dependency.

INSTRUCTIONAL STRATEGIES AND ACTIVITY SEQUENCE

The core of the information is presented in three seminars held one month apart, using interactive lectures, small group discussion, role play, and exercises. Guided attendance at AA/NA and Al-Anon/Nar-Anon is expected between the second and third seminars. Knowledge and skills are reinforced longitudinally with clinical and didactic exercises.

SEMINAR I: Functional Role: Attitudes, Risks, Steps to Diagnosis

Goals of Seminar:

1. Introduction of the faculty development curriculum.
2. Identification and fostering of functional attitudes for clinical care and teaching.
3. Identification of risk factors, assessment of personal risk, and description of preventative counseling.
4. Definition of functional role for the family physician and the importance of the disease concept.
5. Outline the steps to diagnosis and initiating treatment.

Sequence of Activities (2 hours):

15 min. Lecture: Introduction of Curriculum

  a. Why content area is important to practicing family physicians (statistics on frequency, morbidity and mortality).
  b. Why important to family practice teachers (statistics plus paradigm for chronic, relapsing disorder with strong behavioral element and strong impact on family).
  c. Outline of curriculum (activities, exercises, follow-up) and how it will provide needed knowledge and skills.

30 min. Discussion: Societal, resident and personal attitudes, behaviors, and risks.

  a. Show 5 min. clip from Nova describing history of societal attitudes toward alcohol.
  b. Elicit contemporary attitudes through discussion of advertisements and relate these to resident attitudes (no serious attempts to discuss individual personal attitudes of faculty in this group setting).

c. Use discussion to relate attitudes to drug use behaviors and identify high-risk behaviors (lecturer adds other known risk factors).

d. Use conclusions from this discussion to identify problem drug use in self or others, and outline steps to preventive counseling.

10 min. Break

30 min. Interactive Lecture: Steps to diagnosis and treatment

a. Have individuals complete Professional Enablers Form.

b. Use responses to form to stimulate listing why alcohol/drug abusers are "problem patients."

c. Outline how the following lecture will minimize problems by:

1. clarifying MD/FP role
2. describing "functional" attitudes
3. outlining steps to diagnosis and initiating treatment
4. dealing with ambiguity

d. Lecture: Steps to diagnosis and initiating treatment

Refer to handout ("Alcohol and Drug Abuse: A Functional Response for Practicing Clinicians") as the outline and format for this lecture.

20 min. Case discussion

Using the case discussion of a patient presenting with impotence, engage group interactive discussion regarding the steps in diagnostic process (with emphasis on questioning). After initial and subsequent sets of information are given, focus the discussion around these points:

1. what do you want to know now?
2. What specific questions would you ask?
3. At this point, what is your differential? Do you think the patient is an alcoholic?
4. What are your plans for further work-up or follow-up?

Discussion can emphasize specific questions to ask, when to involve the family, dealing with an uncertain diagnosis, and appropriate confrontation and/or follow-up.

15 min. Administer test and collect evaluations

Assign: At the end of the session, the faculty are given two assignments, to be done prior to the next seminar:

a. Self-administer the MAST and/or 26 questions for oneself and a selected close family member (if there is a family member about whose drinking the faculty member has worried).

The faculty are given general options regarding resources if they are concerned regarding conclusions from this exercise.

b. The individual faculty are asked to try a "drug free" weekend (no alcohol, cigarettes, caffeine), preferably one involving a social function.

SEMINAR 2: Involving the Family/Elements of Treatment/Application to Teaching

Goals of Seminar:

1. Review steps in diagnosis and initiating treatment, and outline steps to involve the family.
2. Describe the elements of treatment and identify appropriate treatment options for patient and family, including defining the role of self-help groups.
3. Practice the application of this material to one-on-one teaching.

Sequence of Activities 3 (hours):

15 min. Debrief the "drug free" weekend assignment. Discussion highlighting:

a. Physical/emotional effects of common, socially acceptable psychoactive drugs.

b. The physical consequences of abstaining.

c. Social awkwardness or difficulty encountered.

d. Application to pressures and physical consequences to chemically dependent patients.

5 min. Show confrontation scene from "Cagney and Lacey" TV show (or similar video segment) as a dramatic depiction of an emotional confrontation with an alcoholic.

20 min. Lecture

a. Review primary points from steps to diagnosis and initiating treatment.

b. Outline steps to involving the family of the patient in the diagnostic process.

c. Hand out "Chemical Dependency: A Protocol for Involving the Family."

30 min. Group discussion of questioning, using the videotape by Mac Baird of his interview of an alcoholic patient and his wife.

Discussion to highlight:

a. The need for direct, nonjudgmental approach but the reality of possible/probable physician frustration.

b. The reality of clinical practice, ie, the need to confront judiciously (to minimize chance of patient flight) and to use longitudinal approach.

c. Important role of the spouse and use of protocol to involve him/her in diagnostic process.

10 min. Break

25 min. Lecture

a. Elements of treatment, including the role of self-help groups.

b. Treatment options and identifying the appropriate treatment, based on patient characteristics.

c. Hand out article "Inpatient Alcoholism Treatment: Who Benefits?"

60 min. Role play three one-on-one teaching encounters with surrogate residents. Role play vignettes are designed to highlight or reinforce attitudinal, knowledge, and skill objectives, as well as practice teaching.

a. Vignette 1: Resident whose anger toward substance abuse patient is interfering with dealing with the situation effectively (attitudes).

b. Vignette 2: Resident unclear on how to identify factors important in deciding appropriate treatment for a particular patient (knowledge).

c. Vignette 3: Resident having difficulty with interview, lacks questioning skills (psychomotor skills).

Each role play involves the following protocol:

a. Small group leader sets the scenario.
b. Role play for five minutes.
c. Participant in the role of the faculty gives self-feedback (five minutes max).
d. Group discussion with behavior specific feedback (10 minutes).

15 min. Administer test and collect evaluations.

Assign: Prior to the next seminar (one month), attend at least one AA/NA or Al-Anon/Nar-Anon meeting. (This activity is described more fully in a later section.)

SEMINAR 3: Management of Withdrawal Syndromes

Goals of Seminar:

1. Debrief the self-help group exercise.
2. Recognition and management of withdrawal syndromes for commonly abused drugs.

Sequence of Activities: (2 hours):

15 min.	Discussion of self-help group exercise. Using the questionnaires filled out by the faculty following their attendance at AA/Al-Anon or NA/Nar-Anon meetings, group discussion addresses: a. Strengths/weaknesses b. Facilitating referral c. Minimizing road blocks
5 min.	Videotape clip Videotape segments from movies are used to dramatically present perceptions of drug withdrawal. The DTs segment in "Days of Wine and Roses" is used prior to the first lecture.
30 min.	Lecture: Recognition and Management of Alcohol Withdrawal Syndromes
10 min.	Break
5 min.	Videotape clip Stereotypical view of narcotic withdrawal demonstrated in scene from "Man with the Golden Arm."
30 min.	Lecture: Management of Narcotic, Sedative, and Cocaine Withdrawal Syndromes
15 min.	Case presentation Brief case presentations with discussion highlighting clinical management of withdrawal syndromes.
15 min.	Administer test and collect evaluations.

SELF-HELP GROUP ATTENDANCE

Between the second and third seminars, faculty will be required to attend one AA/NA and one Al-Anon/Nar-Anon/ACOA meeting. The role of self-help groups will be defined at Seminar 2; sign up for selected meetings will be made, and AA/Al-Anon representatives will be selected to attend with the faculty and answer questions. The experience will be debriefed with a questionnaire and discussion at Seminar 3.

Evaluation will be by modified essay questions which will address attitudinal as well as content issues.

CLINICAL/TEACHING EXERCISES

Faculty will be required to turn in assignments at selected times after completing the seminars, focused on clinical and teaching encounters involving substance abuse.

These will involve at least written worksheets, but could also involve audiotapes or videotapes.

Encounters could take place in the family medicine center, hospital, or substance abuse treatment sites. Part of this strategy is to provide medical backup for a treatment program to provide more clinical opportunity.

INSTRUCTIONAL MATERIALS AND RESOURCES

SEMINAR 1

Readings:

1. "Alcohol Abuse, Other Drug Abuse and Mental Disorders in Medical Practice," *JAMA*, April 18, 1986.
2. "Alcoholism: Blocks to Diagnosis and Treatment," Clark, W., *Am J of Med* 1981; 71:275-286.

Audiovisual Aids:

1. "Nova: Under the Influence" (Use segment on societal attitudes).
2. Slides of alcohol product advertisements culled from current magazines.
3. Professional Enabler Questionnaire, Michigan Alcoholism Screening Test (MAST). Available in Principles of *Ambulatory Medicine*, second ed, Ch 21 "Alcoholism."

Materials Developed Specifically for This Component:

1. Handout: "Alcohol and Drug Abuse: A Functional Response for the Primary Care Physician." Appendix A.
2. Case summary with discussion outline. Appendix B.

SEMINAR 2

Readings:

1. "Chemical Dependency: A Protocol for Involving the Family," Baird, MA, *Family Systems Medicine* 1985; 3:216-220.
2. Whitfield CC., et al. Ch. 21: "Alcoholism in Principles of Ambulatory Medicine, 2nd ed., Williams and Wilkins.
3. Gitlow SE and Peyser HS. *Alcoholism: A Practical Treatment Guide*. Grune and Stratton 1980.
4. Miller MR and Hester RK. Inpatient Alcoholism Treatment: Who Benefits? *American Psychologist* 1986; July: 794-805.

Audiovisual Aids:

1. Segment from "Cagney and Lacey" (or other video highlighting family consequences of chemical dependency).
2. Videotape: Baird, Macaran: A Primary Care Approach to Chemical Dependency: Early Detection and Intervention. Oklahoma State Department of Mental Health--Prevention Section; P.O. Box 53277, Capitol Station; Oklahoma City, OK 73152.

Materials Developed Specifically for This Component:

1. Role play vignettes.
2. List of local treatment resources with description of services offered.

SEMINAR 3

Readings:

1. Deveny, P. and Saunders S.: Physicians' Handbook for Medical Management of Alcohol and Drug Related Problems. Addiction Research Foundation, Toronto, Canada 1986.

Audiovisual Aids:

1. Videotape segments from "Days of Wine and Roses" and "Man with the Golden Arm."

Materials Developed Specifically for This Component:

1. Questionnaire regarding self-help group exercise.
2. Case presentations.

EVALUATION STRATEGIES AND INSTRUMENTS

SEMINAR 1

Strategies:

1. Attitudes assessed pre and post with standardized attitudinal questionnaire.
2. Risk factors, high-risk behaviors, preventive counseling: short answer and modified essay questions.
3. Disease concept, FP role: modified essay question.
4. Steps to diagnosis, initiating treatment, elements of treatment, treatment options: short answer and modified essay questions.
5. Chart audit on charts with substance abuse or "red flag" diagnosis.
6. Participants' pre and post self-assessment of competence in relation to seminar objectives.

Instruments:

1. Chappel, JH; Veach, TL; and Krug R.: The Substance Abuse Attitude Survey: An Instrument for Measuring Attitudes. *J Stud Alc;* 46(1):48-52; 1985.
2. Short answer and modified essay style post-test. See Appendix C.
3. Personal Preassessment and Personal Post-Assessment. See Appendix D.

SEMINAR 2

Strategies:

1. Steps to diagnosis and initiating treatment, elements of treatment: short answer questions.
2. Choosing treatment options and involving the family: modified essay questions.
3. Participant's pre and post self-assessment of competence in relation to seminar objectives: questionnaire.

Instruments:

See Appendices C and D for examples of post-test and personal assessment

SEMINAR 3

Strategies:

1. Self-help group knowledge and attitudes: modified essay questions.
2. Recognition and management of withdrawal: short answer and case management style questions.
3. Participant's pre and post self-assessment of competence in relation to seminar objectives: questionnaire.

Instruments:

See Appendices C and D for examples of post-test and personal assessment used in Seminar 1.

ORGANIZATIONAL CONSTRAINTS

1. Possible dysfunctional faculty attitudes	1. **Include attitudinal components early in curriculum sequence, and design group exercise to minimize their threatening character.**
2. Time constraints for faculty.	2. **Identify individuals with power over schedules and involve early to garner support and to solve problems regarding available time.**
3. Faculty resistance.	3. Support from program head to make this a required activity. Present information regarding curriculum plans to faculty prior to implementation date. Motivate regarding applicability to clinical teaching. Use active learning.
4. Funding.	4. Seek grant support (eg, part of residency or predoctoral grant); contract for faculty (and/or residents) to provide clinical care to local treatment facility (also provides motivating factor).

HINTS AND NOTES TO THE INSTRUCTOR

1. Faculty can feel at-risk regarding their own attitudes/behaviors. Focusing Seminar 1 discussions on societal and resident attitudes can decrease the perception of risk, while still prompting thought.
2. Emphasize clinical applicability and actively engage faculty to bring out those elements they find problematic (ie, acknowledge that these can be difficult patients).
3. Stick to role-play feedback protocol to keep role plays low risk.
4. Use articles listed in "Readings" to develop lectures described for those particular seminars.
5. Movie or TV segments used are suggestions but can be adapted to fit instructor taste or availability. Most movies noted are readily available for VCR.
6. Provide a ring binder to hold handouts, readings, exercises, which can be added in sequence and referred to later.
7. Consider printing the local resource list as a folding card, sized to fit in a wallet or schedule book.

APPENDIX

1. Alcohol and Drug Abuse: A Functional Response for the Primary Care Physician
2. Case discussion
3. Post-test
4. Personal assessment

APPENDIX A

ALCOHOL AND DRUG ABUSE: A FUNCTIONAL RESPONSE FOR THE PRIMARY CARE PHYSICIAN

James Finch, MD

DEFINITION:

Drug abuse can be defined as repeated use of a drug, in spite of significant problems in major life areas resulting from its use. The problems can be medical, emotional, familial, financial, or legal. It is characterized by a preoccupation with the drug and loss of control over its use. It is generally chronic, often progressive, and tends toward relapse.

THE MD'S ROLE:

Physicians do not need to feel responsible for getting or keeping someone clean or sober. However, the MD should be able to *recognize* the disorder and help *initiate* the move to treatment by motivating and mobilizing resources.

WHEN TO SUSPECT:

Drug abuse can present to the health care provider in almost endless variety. However, the following problems are so commonly associated with it that they should prompt at least screening questions when seen by the provider:

- Family history of alcoholism or drug abuse.
- Emotional problems (anxiety, depression, marital discord, etc.).
- Sexual dysfunction.
- Trauma (particularly unexplained), including spouse or child abuse.
- Gastric complaints, particularly when recurrent.
- Labile or difficult to control hypertension.
- Frequent Monday "illness" requiring a work or school excuse.
- Any marked change in behavior, particularly in adolescents (decreased school performance, change in peer group, "bad attitude," secretiveness).
- First seizure in an adult.

Other presentations include functional complaints in family members of the patient and abnormal screening labs (see below).

QUESTIONING:

- Focus questions on problems related to alcohol use, not the amount used. This avoids denial and is educational.
- For example, an excellent set of screening questions for alcohol abuse is the C-A-G-E questions (similar questions, looking for problems or loss of control, could be phrased for any substance of potential abuse):

  Have you ever felt the need to CUT down on your drinking?
  Have you ever felt ANNOYED by other's criticism of your drinking?
  Have you ever felt GUILTY about your drinking?
  Have you ever felt the need for an EYE-OPENER or early morning drink?
- Any positive responses are considered suspicious, particularly with evidence of defensiveness, evasiveness, or undue flippancy.
- Pursue suspicions with the MAST (Michigan Alcoholism Screening Test), 26 questions, or similar lines of questioning.
- Question family members. They may be less likely to deny a problem. If they express concern, don't discount it as "nagging."

PHYSICAL EXAM AND LAB:

- As a rule, the physical exam will be normal. Waiting for the "classic" signs of alcoholism or signs of other drug abuse would mean missing the diagnosis the majority of the time.
- However, certain findings are *virtually diagnostic* (eg, withdrawal or "DTs," needle marks, perforated septum).
- Other findings are *highly suspicious* (right upper quadrant tenderness in a regular drinker, unexplained bruises, alcohol on breath during the day).
- Laboratory findings also will generally be *normal*.
- However, frequently found abnormalities are minor elevations in liver function tests (particularly SGOT and GGT) and macrocytosis, with or without anemia (MCV approximately 100) in alcohol abusers.

INITIATING TREATMENT:

If, after your evaluation, you have no evidence of drug abuse but have identified *risks* or problematic issues, identify these to the patient, and leave the door open for future contact.

If you *suspect* drug abuse, but aren't confident in the diagnosis, you have several options:

1. If you haven't talked to the family, *do so*; they may clarify the situation.
2. Follow the patient over time; the pattern of abuse may declare itself.
3. Express your *concern* to the patient, and refer to an appropriate community resource for further evaluation.

If you feel *certain* of the diagnosis of alcoholism or other drug abuse, you should:

1. Tell the patient the diagnosis, as you would with any other illness; directly and nonjudgmentally. Record the diagnosis in the chart.
2. Present it as a "*treatable disease*" which is chronic, recurrent, and out of his or her willful control.
3. Offer treatment options to the patient and his or her family. (Even if the patient does not get help, the family may.)
4. Keep the door open to further contact, regardless of the patient's response to treatment suggestions. The responsibility for change is the patient's, but the physician can continue to offer support and foster compliance.

TREATMENT:

Abstinence is a critical first step, but does not constitute recovery. Sustained abstinence depends upon:

1. Substitute dependencies.
2. Behavior modification through external reminders that drug use is dangerous (eg, medical symptoms, Antabuse).
3. New relationships as sources of sober social support.
4. Increased self-esteem, often through an inspirational source of hope (eg, religious conversion, AA).

Alcoholics Anonymous or Narcotics Anonymous fosters all four of these elements and is included as a vital component of most treatment programs.

Success is improved by marital and social stability, and therefore treatment should also address these issues.

Caveats:

1. Avoid simply suggesting abstinence or cutting down as the solo treatment.
2. Do not use Antabuse as solo treatment.
3. Psychotherapy alone is seldom the treatment of choice for drug abuse.
4. Be familiar with local treatment resources and be comfortable with recommending A.A. or N.A. and Al-Anon or Nar-Anon.
5. Don't forget the family.
6. Remember the "locus of control" and responsibility for getting better is within the patient and his or her family.

APPENDIX B

CASE DISCUSSION

1. Write on a board or flipchart the following minimal information as it would look on a patient's chart, to be seen prior to entering the room:

   Ht. 5'9 55-year-old male with inability to
   Wt.185 lb. achieve erection for 6 months
   BP 138/92

2. Ask: What are your thoughts on seeing this? What do you want to know?
3. After short discussion of thoughts regarding potential differential (possibly including substance abuse), and initial approach to evaluation, provide following information (either piecemeal as elicited by group or as a lump):
   a. Erectile dysfunction for six months: lack of firm erection in all situations, started at stressful time at work (he failed on a project and was threatened with layoff), but that crisis passed months ago.
   b. No symptoms suggestive of cardiovascular, neurologic, genitourinary, or thyroid disease or diabetes.
   c. Basically good health, exercises regularly, and stopped smoking on his own 10 years ago.
   d. Marriage stable but low intimacy level. Two daughters, one 18 at home and one 21 at college.
4. If it has not been brought up, ask if anyone would like to know about the patient's drinking or other drug use:
   a. Why would asking be important?
   b. What would be approach to questioning (what specific questions in what order)?
   c. Elicit CAGE questions and elements of drinking and drug use history.
5. The patient's responses include:
   a. No to all the CAGE questions except:

      Q: "Have you ever felt a need to cut back on your drinking?"
      A: "Well, yeah, I have felt maybe I should but I've never really tried."

   b. He related drinking three to five glasses of brandy per night, starting early in the evening and continuing until he falls asleep. He denies other significant alcohol use and denies any other drug use (prescriptions, OTC, or street). 6.Ask the group for their impression: Do they think at this point that the patient has an alcohol problem? Does anyone think he is an alcoholic?
7. Given some level of suspicion, what would be the next diagnostic options? Elicit or bring up for discussion:
   a. Doing nothing further except possibly physical exam at today's visit (lest the patient be scared away by too much attention to alcohol).
   b. Have patient self-administer the MAST or 26 Questions and then go over responses.
8. The patient's physical exam is entirely normal except the mild diastolic hypertension. It is elected to not pursue questioning any further at this time, but order selected laboratory studies and schedule the patient for follow-up:
   a. How soon should the patient be seen again?
   b. What studies should be obtained?
   c. Should the spouse be included in the next visit?
9. A multi-chem panel and CBC are ordered (plus/minus testosterone), and the patient scheduled to be seen in two weeks, alone (it being felt a little premature to involve the spouse).

   Interim: Multi-chem and CBC normal except MCV 98.

10. On return visit the patient is reassured regarding his normal exam and labs, and a need is expressed to know more about his drinking as a possible contributant to his physical condition. He is given the MAST to self-administer and the results show (use this time as an opportunity to have the group look over the MAST):
    a. Patient circled number 1: "I do seem to drink more than most people I know."
    b. Patient puts question marks next to numbers 4 and 7. (On questioning he replies, "I don't know if I could cut back or stop. I think it would be kinda tough.")
11. What is the groups' impression at this point? Does anyone think the patient is an alcoholic? What would be the next diagnostic or therapeutic options?
    a. Have patient return for follow-up with his wife?
    b. Express your concern and follow over time, awaiting "clear" signs of abuse?
    c. Suggest a trial of reduced, controlled drinking, and follow-up?
    d. Refer for further evaluation and/or treatment?
12. The patient is very resistent to having his wife in ("we are rarely intimate and I don't want to discuss this with her"). Still having some ambivalence about the diagnosis, the patient is given a trial of controlled drinking (no more than one 4-oz. brandy per 24-hour period) and scheduled for follow-up in one month.
13. On follow-up, the patient states he feels great! He hasn't had a drink since the last visit. Rather than just cut back, he stopped entirely. He now stays up later at night since he is less sedated, and while at a business convention he went to bed with his secretary and had no erectile dysfunction. He is not interested in further work up or more discussion of his marital relationship. He thanks you for your help.
    a. What are the group's impressions at this point?
    b. What about the results of the controlled drinking trial?
    c. Does anyone feel certain the patient is an alcoholic?

Summation: This case is used to highlight a nonstereotypical alcoholic, presenting with a common clinical problem, with an ambiguous diagnostic process.

APPENDIX C

FACULTY DEVELOPMENT
SEMINAR POST-TEST

1. Please refer to the reproductions of three advertisements recently run in several large circulation magazines. For each of these ads, describe the alcohol use behaviors condoned or reflected by the ad. Choose whether these ads are supportive of low-risk drinking or conducive to alcohol abuse. (Note: Ads selected for this depict associations between alcohol and intimacy, power, machismo, etc.)

2. List five common clinical conditions which are frequently associated with alcohol abuse.

   a.

   b.

   c.

   d.

   e.

3. List two historical factors (familial or individual) indicating increased risk for substance abuse.

   a.

   b.

4. List two common screening lab values which might indicate hidden alcohol abuse.

   a.

   b.

5. Mr. O'Rourke is a 40-year-old mid-level business executive with three children. His father died when he was five years old of a "bleeding ulcer," but his family denies any history of alcoholism. He drinks some amount of alcohol daily (business lunches, to "loosen up" at cocktail or business parties, or a "drink to relax" after a hard day). He is rarely noted to be "drunk," however. He works long hours and is successful.
   His visits to your office have noted only moderate obesity, occasional trouble with his nerves, and diastolic BPs intermittently in the 90s.

   a. List at least four factors which might raise your index of suspicion for alcohol abuse

      1.

      2.

      3.

      4.

   b. List the initial questions (specific wording) you would ask Mr. O'Rourke to investigate this suspicion.

   c. If the patient's responses raised your suspicions further, describe at least two strategies you could next pursue to obtain more information.

      a.

      b.

   d. If after your direct, nonjudgmental questioning and follow-up investigation you find no clear evidence of anything more than some historical and/or behavioral risk factors, write out a "prescription" for low-risk drinking behavior, including warning signs for alcohol abuse.

   e. If, however, after your investigation you still suspect, but are unsure of, a hidden abuse problem, list at least three options you have as a family physician.

      1.

      2.

      3.

APPENDIX D

Alcohol and Drug Abuse: Functional Skills for the Practicing Clinician

PERSONAL PRE-ASSESSMENT

Name: ________________________________

Instructions

This questionnaire lists each of the workshop's instructional objectives and asks you to estimate the degree of confidence you have with respect to the knowledge and/or skill specified. Circle the ONE best response code.

Response Codes

5 for "VERY CONFIDENT", secure that I have mastered this objective.

4 for "CONFIDENT" that I can adequately deal with this objective.

3 for "NO PARTICULAR FEELINGS" about this objective; not definite.

2 for "INSECURE", knowing that I probably could not deal with this objective.

1 for "VERY INSECURE", knowing that I definitely could not deal with this objective.

Instructional Objectives

1. Describe the impact of chemical dependency in terms of frequency, morbidity, and mortality, and relate this to the importance of family physician expertise in this area.

   CONFIDENCE: [5] [4] [3] [2] [1]

2. Describe the role of attitudes in fostering substance abuse in individuals or groups

   CONFIDENCE: [5] [4] [3] [2] [1]

3. Define high-risk drinking behavior and provide preventive counseling against alcohol abuse

   CONFIDENT: [5] [4] [3] [2] [1]

4. Define an appropriate role and functional attitudes for a family physician in regard to patients with chemical dependency

   CONFIDENCE: [5] [4] [3] [2] [1]

5. Outline the steps involved in diagnosing and initiating treatment for substance abuse

   CONFIDENCE: [5] [4] [3] [2] [1]

6. Describe several circumstances in which the family of the chemically dependent patient might be involved in the diagnostic or treatment process

   CONFIDENCE: [5] [4] [3] [2] [1]

PERSONAL POST-ASSESSMENT

Name: ________________________________

Instructions

This questionnaire lists each of the workshop's instructional objectives and asks you to estimate the degree of confidence you have with respect to the knowledge and/or skill specified. Circle the ONE best response code.

Response Codes

5 for "VERY CONFIDENT", secure that I have mastered this objective.

4 for "CONFIDENT" that I can adequately deal with this objective.

3 for "NO PARTICULAR FEELINGS" about this objective; not definite.

2 for "INSECURE", knowing that I probably could not deal with this objective.

1 for "VERY INSECURE", knowing that I definitely could not deal with this objective.

Instructional Objectives

1. Describe the impact of chemical dependency in terms of frequency, morbidity, and mortality, and relate this to the importance of family physician expertise in this area

   CONFIDENCE: [5] [4] [3] [2] [1]

2. Describe the role of attitudes in fostering substance abuse in individuals or groups.

   CONFIDENCE: [5] [4] [3] [2] [1]

3. Define high-risk drinking behavior and provide preventive counseling against alcohol abuse.

   CONFIDENCE: [5] [4] [3] [2] [1]

4. Define an appropriate role and functional attitudes for a family physician in regard to patients with chemical dependency.

   CONFIDENCE: [5] [4] [3] [2] [1]

5. Outline the steps involved in diagnosing and initiating treatment for substance abuse.

   CONFIDENCE: [5] [4] [3] [2] [1]

6. Describe several circumstances in which the family of the chemically dependent patient might be involved in the diagnostic or treatment process.

   CONFIDENCE: [5] [4] [3] [2] [1]

Anton J. Kuzel, MD

A Brief Intervention Strategy for Faculty Development in Chemical Dependency Syndrome

CONTENTS

Page
Curriculum Example Description 87
Appendices:
Outline of Introduction to Unit and Needs Assessment 89
Clinical Case Vignettes 90
Sample Script for Simulated Patient 91
Learner Tape Review Guide 92
Facilitator Tape Review Guide 92
Exit Interview Guide 92

ACKNOWLEDGEMENTS:

The author gratefully acknowledges the grant support from the NIAAA and NIDA which made this curriculum development project possible. Thanks also to the entire STFM grant committee and the other fellows who participated in the project for their helpful advice during the development of this instructional unit. Finally, the author expresses his deep appreciation to the staff of the Comprehensive Addiction Treatment Services Program at Fairfax Hospital - Maureen Schneider, William Paley, Tek Konkel, and John Hewitt - who volunteered their time and without whose assistance this project would not have succeeded.

Anton J. Kuzel, MD
Fairfax Family Practice Residency Program
Medical College of Virginia
3650 Joseph Siewick Drive, #400
Fairfax, Virginia 22033
703-391-2020

A BRIEF INTERVENTION STRATEGY FOR FACULTY DEVELOPMENT IN CHEMICAL DEPENDENCY SYNDROME

CONTEXT

Setting
Family Practice Residency Program - Community Hospital

Level of participants
Faculty

Contact time
3.5-5 hours (plus additional 4-6 hours of independent time by learner)

How Tied into Overall Curriculum
Voluntary faculty development module which may be organized and implemented from within or from without the residency program

Scope of Substances Covered
Both alcohol and other drugs

RATIONALE

Improved faculty skills are required for improvement in resident instruction on chemical dependency. The most pragmatic knowledge, attitudes, and skills are those which relate to the office diagnosis of and intervention into chemical dependency, and appropriate use of community resources for its treatment.

OBJECTIVES

Knowledge

1. Demonstrate knowledge of the diagnostic criteria for abuse and dependency
2. Demonstrate knowledge of the diagnostic data sources (patient history, physical, labs; family, friends, employer)
3. Demonstrate knowledge of intervention strategies
4. Demonstrate knowledge of community resources for aid in diagnosis and treatment

Attitude

1. Exhibit a nonjudgmental attitude while gathering information and presenting the diagnosis
2. Exhibit care and concern in presenting the diagnosis and treatment recommendations
3. Exhibit acceptance of patient resistance or anger

Behavior

1. Interviews for general exam include screening questions
2. When appropriate, follow-up questions are used
3. When appropriate, a full substance use history is taken
4. When the diagnosis is in doubt, other sources of data are sought, data is gathered over time, etc.
5. When the diagnosis is clear, the information is presented to the patient (and to family, friend, or employer, if appropriate) and proper treatment is prescribed
6. Continued involvement with the patient is maintained, whether the patient agrees to treatment or not

The objectives clearly emphasize the development of diagnostic and simple intervention skills. This unit does not stress knowledge in other areas, such as the epidemiology of substance abuse, the details of inpatient and outpatient therapy, or physician involvement in the long-term management of chemically dependent patients in recovery. It is anticipated that those physicians who complete this basic unit of instruction will be stimulated to learn more about those topics which were not stressed, and the instructional unit materials will include resources to assist them in further learning.

INSTRUCTIONAL STRATEGIES AND ACTIVITY SEQUENCE

Session/Time	Instructional Strategy/Activity
Session 1 15-30 min.	Introduction to course and needs assessment (Appendix A) Previous training and experience Self-assessed strengths and areas to improve
Session 2 4-6 hr.	Self-instruction Based on information from needs assessment Includes selected readings, videotapes (with study guides), programmed learning units (if available)
Session 3 30 min.	Discussion group Review key concepts from instructional materials Clarify any confusion arising from materials Evaluate utility of instructional materials
30 min.	Introduction to tape review Review of "example" tape (author and simulated patient) Use learner tape review guide (Appendix D) Select vignette for simulated patient (Appendix B) or choose patient from practice and schedule taping
Session 4 30 min. 30-60 min.	Videotape simulated or actual patient Review tape with facilitator and course director Learner again uses tape review guide (Appendix D) Facilitator uses tape review guide (Appendix E)
Session 5 1-1.5 hr.	Repeat videotaping and review, one to two weeks later
Session 6 15-30 m.	Exit interview (Appendix F)

INSTRUCTIONAL MATERIALS AND RESOURCES

Readings:

1. Weinberg JR, Interview techniques for diagnosing alcoholism, *Am Fam Phys* 9:107-15, 1974
2. Heilman RO, Early recognition of alcoholism and other drug dependence, Hazelden publications
3. Cyr MG, Wartman SA, The effectiveness of routine screening questions in the detection of alcoholism, *JAMA* 259:51-4, 1988
4. McHugh MJ, The abuse of volatile substances, *Ped Clin* NA 34:333-40, 1987
5. Schwartz RH, Marijuana: an overview, *Ped Clin* NA 34:305-17, 1987
6. Anglin TM, Interviewing guidelines for the clinical evaluation of adolescent substance abuse, *Ped Clin* NA 34:381- 98, 1987
7. The Coping Catalog, Washington Area Council on Alcohol & Drug Abuse, 1986
8. McCarron MM, Phencyclidine intoxication, in Phencyclidine: An Update, DH Clouet, ed., NIDA Research Monograph 64, Rockville, Md: NIDA, 1986
9. Manno JE, Interpretation of urinalysis results, Urine Testing for Drugs of Abuse. Research Monograph Series, No. 73, Rockville, MD. NIDA, 1986
10. Estroff TW, Medical and biological consequences of cocaine abuse, in *Cocaine*, Washton AM and Gold MS, ed., New York: Guilford Press, 1987
11. Chemical Dependency & Recovery are a Family Affair, Minneapolis: Johnson Institute, 1979
12. Mooney AJ, Alcohol use, in *Health Promotion: A Guide to Clinical Practice*, Taylor RB, ed., Norwalk: Appleton-Century- Crofts, 1982

Audiovisual Aids:

1. Alcoholism and the Physician, Parts 1-4. Hazelden Educational Materials. Box 176; Center City, MN 55012.
2. Baird MA, Primary Care Approach to Chemical Dependency: Early Detection and Intervention Oklahoma State Department of Mental Health Prevention Section, P.O. Box 53277, Capitol Station, Oklahoma City, OK 73152

Materials Developed Specifically for this Component:

1. Assessment, Tape Review, and Exit Interview Guides (Appendices A,D,E,F)
2. Example videotape of interview with simulated patient
3. Vignettes, ie, scripts for simulated patients (Appendices B,C)
4. Study guides to accompany written and AV instructional materials

Faculty/Instructors:

1. Course director (preferably a family physician with some expertise in substance abuse diagnosis and treatment)
2. One or more individuals to play the role of "patients" in the vignettes (preferably treatment professionals)

Other Necessary Materials and/or Resources:

1. Videocamera
2. VCR/TV

EVALUATION STRATEGIES AND INSTRUMENTS

Strategies:

1. Pre-assessment of needs; feedback on instructional materials; tape review sessions (initial, two to four weeks); exit interview.
2. Directed self-evaluation which is descriptive and behavior- specific (1,2).
3. Use of interview format (qualitative evaluation (3)) to obtain detailed information and to better allow for program development that reflects learners' needs.
4. Asking learners for feedback on course director's understanding of their needs, their comprehension ofinstructional materials, and their opinion of the course ("member-checking" [3]).

Instruments:

1. Needs assessment (Appendix A)
2. Learner tape review guide (Appendix D)
3. Facilitator tape review guide (Appendix E)
4. Exit interview guide (Appendix F)

ORGANIZATIONAL CONSTRAINTS

Constraints	**Suggestions to Overcome**
1. 7.5-11 hours of learner time to complete unit	1. Schedule as CME time; use "free" time; present as weekend retreat
2. 3.5-5 hours of course director time per learner	2. Work with one or more pairs of faculty at a time
3. Uneven level of faculty interest	3. Use volunteers; positive initial experience will increase interest

HINTS AND NOTES TO THE INSTRUCTOR

1. The unit in its present form is time intensive for the instructor. Allow adequate time or modify the format (eg, more large group instruction and observation of interviews) if this is needed to reduce the time investment for the course director.
2. Identify individuals who can serve as the simulated patients in the vignettes. Counsellors from local treatment programs are ideal for this role.
3. Either audiotape the needs assessment and exit interviews or keep notes.
4. Keep the instructional materials to a minimum, ie, provide only one best article or videotape on a given topic. Experience with this unit at the author's home program has shown that the interviews with simulated patients and the analysis of same is consistently rated at the most effective teaching tool in the unit.
5. Study guides with focus questions on the written or AV teaching materials help direct the learner and provide a structure for the discussion in the first group session.

REFERENCES

1. Kagan N. Interpersonal Process Recall: A Method for Influencing Human Interaction, East Lansing: OMERAD, Michigan State University, 1975
2. Berquist WH, Phillips SR, A Handbook for Faculty Development, Washington: The Council for the Advancement of Small Colleges, 1975
3. Guba E, Toward a Methodology of Naturalistic Inquiry in Educational Evaluation, Los Angeles: Center for the Study of Evaluation, University of California, 1978

APPENDIX A

OUTLINE OF INTRODUCTION TO UNIT AND NEEDS ASSESSMENT

- Introduction to instructional unit
  - Importance to society
  - Relevance to family practice
  - Recognition of variability of training in SA
  - Statement of goal, objectives
  - Place within larger framework of knowledge/skills
    - Inventory of topics and subtopics (see last page of this appendix)
    - Encourage self-instruction in other areas
    - State choice made was based on crucial need to identify and intervene with CDS patients
- Interview guide for needs assessment
  - Describe your training in interview techniques
    - When? By whom? Was videotaping included?
  - Describe training in CDS
    - When? By whom? Inpatient? Outpatient? Did it cover office diagnosis? Intervention/referral? Detox? Individual therapy? Group therapy? Long-term management?
  - Relate post-training experience with CDS patients
    - Numbers
    - Variety (alcohol, other drug)
    - Personal assessment of ability in diagnosis, intervention, and referral
    - Feelings about/reactions toward CDS patients
  - Areas of need (use inventory guide again)
- Patient management problems/clinical vignettes
  - (May be used to help learner focus on his/her needs)
    - (For each vignette, the following questions may be asked.)
    - What experience have you had with a patient like this?
    - What sorts of hypotheses or differential diagnoses run through your mind given this brief description?
    - What information do you need to sort out those possibilities?
    - How would you gather the information you need?
- Possible PMP categories:
  1) Evaluation for ADS in patient who doesn't see need for same but is being seen under duress
  2) Polydrug dependent patient
  3) Narcotic dependent patient
  4) Medical or psychiatric problem as presentation of drug dependency
  5) Adolescent patient suspected of drug abuse
  6) Special cases, eg, drug use in pregnancy, AIDS, and CDS, etc

Inventory of Areas for Knowledge/Skill Development in Chemical Dependency

The following major topics and subtopics may be considered:

- GENERAL CONCEPTS
  - Epidemiology
  - Family
- PREVENTION
- PATHOPHYSIOLOGY
- EVALUATION OF THE PATIENT
  - **Screening**
  - **Differential Diagnosis and Diagnosis**
  - **History Taking**
  - **Physical Examination**
  - **Laboratory Investigations**
- MANAGEMENT
  - **Intervention**
  - **Acute Management**
  - **Referral**
  - **Community Treatment Resources**
  - **Self-Help Groups**
  - **Long-Term Groups**
  - **Use of Psychotropic Medications**
  - **Therapeutic Relationship**
- LEGAL ASPECTS
- HEALTH PROFESSIONAL IMPAIRMENT

Those topics in bold print receive special emphasis for this faculty development course, but resources for learning are available or can be developed for any area of interest for the learner. Teaching materials are available for both alcohol and specific other drugs.

APPENDIX B
CLINICAL VIGNETTES

CDS case 1

Name: Jack Green
Age: 40
Sex: male
Reason for office visit: problems with nose
Brief history as presented by patient: "I think I might have destroyed the inside of my nose a couple of weeks ago after I snorted some coke. My wife says I should see a doctor about it, so here I am."

CDS case 2

Name: Jerry Kowalski
Age: 40
Sex: male
Reason for office visit: "I'm under a lot of stress lately and I thought you could maybe give me something just for awhile to help me get through it."
Brief history as presented by patient: finding it harder to concentrate at work; got a traffic ticket recently and threatened loss of driver's license; not eating as well—just not as hungry; wife just found out that she's expecting (their first)—he's happy but concerned about finances; sometimes hard to get to sleep, but not usually; feels tired in the morning, but no early awakening; denies feeling depressed, just stressed; requesting something for his nerves just for awhile.

CDS case 3

Name: Joleen Arthur
Age: 18
Sex: female
Reason for office visit: "My parents are worried about my health and wanted me to see a doctor."
Brief history as presented by patient: "I guess I look kinda run down and my parents got worried and said I should see a doctor." Hasn't been eating as much lately, lost a few pounds in the past few weeks; no symptoms of depression other than loss of interest in recreational activities and feels tired most of the time for the past month; broke up with boyfriend (lots of arguments) a week ago; stays up late a lot; used to work as a waitress, stopped working about a month ago; living with friends.

CDS case 4

Name: Alan Vale
Age: 52
Sex: male
Reason for office visit: hypertension
Brief history as presented by patient: recently moved to area from Houston; has had high blood pressure for five years and is on Tenormin; last check up six months ago, no problems except blood pressure; no change in dose since starting medicine; wants to establish with doctor in this area and get prescription for more Tenormin.

CDS case 5

Name: Brian Wilson
Age: 16
Sex: male
Reason for office visit: "My mom is worried about me, I guess. I don't think I need to be here, but she made me come. I don't know why I had to come here." (This is a patient and family whom you have known for five years.)
Brief history as stated by patient: "She says I haven't been acting right lately. She says my grades are dropping and she thinks I'm doing drugs or something, but I just think the classes are useless. She's always on my back about my friends, too, and makes me come home by midnight even on the weekends. Of course, I don't always do that, so she gets mad. I bet you wouldn't make your kids come home so early if they were my age. Personally, I think she's just uptight ever since she and Dad split up a year ago. We had to move to a condo and she had to go back to work full time, and ever since then she just seems to be on my back about everything. I guess she's talked to you, right?" (You have known the Wilson family for five years. Brian was last in two years ago for a school physical. He has had no significant medical or behavioral problems to date. His mother, Marilyn, is also a patient in your practice and has talked to you a week ago during her office visit about her son, Brian. She has found a marijuana cigarette in his room, and he has twice come home after curfew "stoned" as far as she could tell. She requests that you see Brian and do a urine toxicology screen.)

CDS case 6

Name: Janet Davis
Age: 46
Sex: female
Reason for office visit: Follow up on stress and difficulty sleeping.
Brief history as presented by patient: "I did all the things you asked me to do on the last office visit and I'm still having trouble sleeping. I think it's my nerves. I think I need something stronger to help me get a good night's sleep. I'm sure that everything else would work out if I just felt better—not so tired all the time. I need to get some decent sleep." (Janet has been your patient for three years, and comes in each year for regular checkups. Six months ago she described some worries which were causing her to have trouble sleeping—waking up frequently, and feeling tired in the morning. She requested and received a prescription for Halcion for two weeks, plus one refill. She came back two months later requesting more, but you suggested stress reduction techniques and prescribed tryptophan and relaxation therapy at bedtime, with instructions to follow up in one month. You had also asked to limit her consumption of caffeine and alcohol to no more than two servings of each per day. Her characterization of her alcohol consumption at her last interview had been vague but not defensive.)

APPENDIX C

SAMPLE SCRIPT FOR SIMULATED PATIENT

CDS case 4

Name: Alan Vale
Age: 52
Sex: male
Reason for office visit: hypertension

Brief history as presented by patient: recently moved to area from Houston; has had high blood pressure for five years and is on Tenormin; last check up six months ago, no problems except blood pressure; no change in dose since starting medicine; wants to establish with doctor in this area and get prescription for more Tenormin

Standard medical history: HPI: first told had high blood pressure five years ago; started on diuretic but got leg cramps, so was switched to Tenormin four years ago; blood pressure sometimes just a little high when checked but attributes this to not liking to go to doctor's office—physician in Houston never changed dose of medication; only side effect he knows of is occasional difficulty getting or maintaining erection—problem a bit more frequent now (patient wants to know if there might be a better medicine for him); no medical complications from HTN that he knows of PHx: Medical—none; Surgical—appendectomy as a child; Medications—Tenormin, occasional OTC sleeping pill; Allergies—none FHx: father died, 60, ''internal bleeding'' SHx: smokes 1 PPD for 30 yrs; 2-3 cups coffee/day; alcohol— ''socially and with dinner;'' works as executive for commercial construction company; second marriage for 10 yrs, two step- daughters ages 13 and 17 (wife widowed—her first husband killed in auto accident)

Substance use history as given by patient: defines ''social'' drinking as ''one or two'' during business lunch or dinner; has wine with dinner at home most days and ''likes to relax with an after-dinner drink;'' drinks alone ''sometimes when my wife goes to bed early or when I have trouble falling asleep, I'll sit and watch TV and have a drink;'' wife ''thinks I should cut back because of my blood pressure, I guess, but then she wants me to stop smoking, too;'' denies any health problems from drinking or physician concern in the past; denies blackouts, withdrawal symptoms, work or legal consequences

Degree of patient defensiveness: moderate

Brief description of defensive tactics: evasive, vague answers; minimizing; when too much attention paid to drinking, says he has an appointment elsewhere and requests prescription for Tenormin

Results of PE: BP 160/100, P 80, regular Skin—few telangiectasias on nose, cheeks, actinic keratoses on cheeks, ears, forehead Lungs—slightly increased AP diameter and decreased breath sounds Remainder of PE unremarkable

Diagnostic assessment based on information initially available: Hypertension—control not adequate, but need some readings from outside the office to see if patient's contention that high readings are ''white coat'' HTN is correct; alcohol use contributing to HTN; difficulties with impotency interpreted by patient as medication side effect—probably won't consider ethanol as contributing.

Problematic alcohol use—using as medicine, drinking alone, may be contributing to or causing HTN; patient admits to wife expressing concern about his drinking, but minimizes and evades; when pressed about alcohol use, becomes more defensive and pushes for addressing HTN; telangiectasias hard to interpret given concurrent signs of solar skin damage; need more data gathered over time from patient and from other sources, such as wife; need lab data Solar skin damage—need cryo and prevention of more damage

Recommendations given above: need to ''titrate relationship'' here and not push too hard on alcohol use and consequences, or may lose patient since he is new to practice; can renew medication for a month and recommend BP monitoring outside of office, and return visit within the month for follow-up

Results of recommendations: patient agrees to get BP checks at work (employee health nurse) and to return for follow-up within a month

Substance use history and related information available from patient and other sources: patient: comes in in one month and following data is obtained—

first use—16

last use—evening before office visit, 2-3 drinks

pattern—alcohol; 4-6 1.5 oz. drinks/day, sometimes more on weekends; heavier use over past four months; prior to that 6-10 drinks per week for five years; prior to that 2-4 drinks per week since age 21 longest period of abstinence in past 4 months—3 days treatment history—saw intake counsellor at Alexandria Hospitaldue to wife's ''nagging'' two months ago, was recommended to undergo inpatient treatment, but didn't because ''I'm not an alcoholic, and besides, I can't afford that kind of time off from work.''

family history of CDS—father was a heavy drinker, could have contributed to his death; patient thinks he died from a bleeding ulcer; patient's father ''never liked going to doctors''

family effects of substance use—wife on his back about his drinking; older step-daughter ''a typical adolescent''—lots of fights and screaming and threats to leave home, though patient doesn't connect fights with his drinking; younger step-daughter quiet, well-behaved, doing very well in school—''never a problem''

employment effects—denies; states that he knows some people at work ''who really have a drinking problem, and I'm not like them— I can control my drinking''

legal effects—denies

physical effects—denies

withdrawal symptoms—denies

laboratory data: CBC, chem 24, UA, EKG normal; CXR shows some loss of interstitial markings and mild flattening of diaphragm

MAST: 8

wife: concerned that patient is ''killing himself with his drinking''; worried that he's going to have a heart attack; reports that he is more irritable and verbally abusive to her and her older daughter when he has been drinking; admits to being angry with patient because he refused treatment when recommended a couple months ago; Al-Anon suggested to her by counsellor but she ''hasn't gotten around to going—anyway, Al's the one who has to do something about his drinking''

Diagnostic assessment based on full data base: Alcoholism, early to middle stages—use as medication, tolerance likely, continued use despite adverse family consequences, very defensive about use, has already been diagnosed as alcoholic by specialist yet continues to drink and refuses treatment

Recommendations given full data base: obtain permission to get records of CDS counsellor's assessment; point out the adverse consequences of drinking; point to MAST score and significance of score of 5 or more; recommend repeat evaluation by counsellor, for purposes of being certain of diagnosis and recommending therapy

Summary of results of recommendations: patient agrees to see counsellor, then cancels appointment; doesn't keep next office appointment, and doesn't respond to letter you send to urge follow-up and to express your continuing wish to provide his health care; wife agrees to attend Al-Anon

APPENDIX D
LEARNER TAPE REVIEW GUIDE

- Information gathering
  - What data did you get regarding history of use of alcohol/ other drug? (anticipate a checklist of key points)
  - Is diagnosis clear?
  - If not, what data is needed and how do you try to get it?
    - Patient (further interview, MAST, referral)
    - Family, friends, employer
    - Laboratory
  - Were your plans for further data-gathering stated in the encounter?
- Patient reaction
  - How did patient show resistance, denial, anger, or minimizing?
  - How did you deal with these reactions?
- Assessment of patient
  - What conclusion did you reach by the end of the encounter?
  - How did you communicate this to the patient?
  - How did the patient receive this information?
  - Given your conclusion, what may you recommend as the next step?
  - How did the patient receive your recommendation?
- General assessment of encounter
  - What aspects of the encounter do you think went especially well?
  - What would you do differently if you were to repeat the encounter?

APPENDIX E
FACILITATOR TAPE REVIEW GUIDE

Follow the learner's lead in deciding what to comment on—don't cover topics or areas that the learner hasn't already opened unless you deem them to be crucial, and then do so gently.

Be inquiring—avoid labeling student behavior.

Suggested additional comments and questions:
- "I thought these parts of the interview were done especially well:...."
- "You might consider (   ) as an alternate approach to that situation next time."
- "Do you have any questions that I can try to answer regarding data gathering, diagnosis, or disposition for this patient?"

APPENDIX F
EXIT INTERVIEW GUIDE

- Please restate the subtopics of chemical dependency syndrome upon which you chose to focus at the outset of this unit:
  - (May choose to reintroduce a copy of the inventory guide used in the needs assessment interview [see last page of Appendix A])
- In which of these areas do you feel you have achieved your goal of knowledge, attitude, or skill development?
  - What materials or methods within the unit did you use?
  - What were most useful in achieving your goals?
  - What were not useful?
- How are your skills now in your practice, ie, did this material transfer to your practice? (Please remember that the focus of this unit is on screening, diagnosis, simple intervention skills, and use of community resources.)
- In what way will this unit affect how you teach chemical dependency knowledge and skills to residents?

Jerome E. Schulz, MD

"How to Stay Sober and Serene in Dealing with Alcoholic Patients"

CONTENTS

Page
Curriculum Example Description 95

Appendices:
Red Flags and What to Do With Them 97
Getting at the Diagnosis: Early Signs and Symptoms (to help diagnosis) 98
What to Do 99
"Comfortability and Competency" Scale 100

Jerome E. Schulz, M.D.
Family Practice Residency Training Program
St. Paul-Ramsey Medical Center
640 Jackson Street
St. Paul, Minnesota 55101
(612) 221-3540

HOW TO STAY SOBER AND SERENE IN DEALING WITH ALCOHOLIC PATIENTS

CONTEXT

Setting and Level of Participants

This is a presentation for medical students, residents and practicing physicians that will focus on the initial evaluation and management of chemically dependent/alcoholic patients in primary care settings.

Contact Time

This will be a 90- to 180-minute seminar.

How Tied into Overall Curriculum

This will be a separate seminar to be presented at CME courses or included in a broader curriculum of chemical dependency presented to medical students and/or residents.

Scope of Substances Covered

This presentation will cover primarily alcohol, and it also has a broader application to chemical dependency in general.

RATIONALE

There are two major stumbling blocks in the management of the alcoholic/chemically dependent patient in a primary care physician's practice. The first major block is a lack of knowledge about how to make the diagnosis of chemical dependency. The second block is a lack of understanding of what to do once the diagnosis has been established. The physician's anxiety can be lessened by applying certain basic guidelines and practical usable techniques in dealing with chemically dependent patients. With this decreased anxiety, the physician will be better able to manage chemically dependent patients and assist them in becoming involved in effective treatment programs.

OBJECTIVES

The participants will learn:

Knowledge

1. The major red flags that may point to a diagnosis of chemical dependency/alcoholism in primary care patients.
2. The importance of individualized accurate data gathering and simple, direct questions that will assist in establishing the diagnosis of chemical dependency.

Skills

3. Possible options for effective treatment in their particular community setting and how and where to learn about these options.
4. The use of "formal interventions" in motivating chemically dependent patients to enter treatment programs.

Attitudes

5. That chemically dependent patients can be diagnosed and helped to get effective treatment by the primary care physician.
6. That families can be helped and that an intervention is not a failure even if the chemically dependent person continues to use chemicals.

INSTRUCTIONAL STRATEGIES AND ACTIVITY SEQUENCE

This seminar can be broken into three separate modules that can be modified depending on the time available for the seminar.

Module 1 15-30 min.	Identification of "red flags" in the history and physical to help the physician be suspicious of chemical dependence in a patient.
Module 2 15-30 min.	The confirmation of the diagnoses by specific questions and laboratory tests. An excellent method to use to help teach interview techniques is to have a simulated patient interview with the participants each asking the "patient" questions that they would use to help them confirm the diagnosis of chemical dependency.
Module 3 45-90 min.	Strategies to present the diagnosis to the patient and the family including strategies to help break through the denial and assist the patient in obtaining appropriate help.
Module 3a 45-60 min.	Role play a formal intervention with the seminar participants assuming the roles of the chemically dependent patient, the family and the other important people in the patient's life.

These modules can be presented using several teaching methods depending on the time available and the size of the group. If the group is small, a small group discussion and brainstorming technique is very effective in getting active audience participation. For larger groups, a lecture format may be necessary. The simulated patient role play is a very effective method to teach the interview techniques and graphically demonstrates what questions are most effective.

INSTRUCTIONAL MATERIALS AND RESOURCES

Readings:

1. How to Use Intervention in Your Professional Practice. Minneapolis: Johnson Institute Books, 1987.

Audiovisual Aids:

1. Flip board or blackboard
2. Slides or overhead projector (if lecture format is used)

Materials Developed Specifically for This Component:

1. Outline: "Red Flags and What To Do With Them" 2. Summary sheet with names, telephone numbers and addresses of treatment programs, chemical dependency specialists and AA contacts in your area

Faculty/Instructors:

1. Primary care physician or physicians with expertise in chemical dependency
2. Chemical dependency counselor or intervention specialist

Other Necessary Materials and/or Resources:

None

EVALUATION STRATEGIES AND INSTRUMENTS

1. Brief Seminar Evaluation Form
2. Comfort/Competence Self-Assessment Scale on Chemical Dependency

ORGANIZATIONAL CONSTRAINTS

Constraints	**Suggestions to Overcome**
1. The negative attitude about chemical dependency in the physician.	Make the title and course summary as practically oriented and appealing as possible.
2. The unwillingness of CME courses to give sufficient time to present the above material.	Work with the course organizers to help them understand and appreciate the importance of the subject. Contact the local medical school and medical groups and let them know about the availability of the seminar.
3. Convincing people that the program will be useful in their primary care practices and that the program is important enough so that they will attend the seminar.	Make the seminar as practical as possible with experiential teaching and practical usable handouts. If plenary sessions are being presented at a CME course, give a general plenary presentation on chemical dependency that can be an attraction to the more indepth seminar.
4. Getting the time to organize and plan the seminar.	Use a basic outline (such as the guide in the appendix) as a framework for the small group discussion on the red flags. Use a chemical dependency counselor to assist in the role play intervention if you have had no experience in intervention.
5. Lack of experience or expertise in chemical dependency.	Use local chemical dependency counselors or recovering people in Alcoholics Anonymous to help with the overall planning of the seminar and more specifically to assist in the role plays.

HINTS AND NOTES TO THE INSTRUCTOR

1. This seminar works best in small groups (maximum 20 people). It can be presented in a lecture format if the group is large; it is very difficult to maintain the interest level if the whole seminar is done by lecture. If a small group method is used, the participants will maintain a higher level of interest with the interactive teaching method.
2. For the presentation of the second module (the confirmation of the diagnoses), a successful teaching method is to ask the participants what their favorite questions are to help them substantiate the diagnosis of chemical dependency when they are suspicious. If there is enough time, the role play with a recovering alcoholic is very effectively used for this module. The local AA community is an excellent resource for volunteers. You need to allow sufficient time for the participants to discuss which questions were most helpful and which questions were most frustrating and least helpful.
3. The role play of the intervention is an extremely powerful teaching tool. This is the particularly unique aspect of this curriculum. It will demonstrate the very strong emotions and feelings that can be generated in confronting chemical dependency in a primary care setting even when it is only role played. It will also show that this energy and emotion can be used in a positive way to help families suffering for chemical dependency. The intervention needs to be carefully planned (the same way an actual intervention is planned in the pre-intervention session) and carefully controlled by the group leader.
4. The group needs to have sufficient time after the role play to process what has occurred and the participants should be allowed time to share the feelings that they experienced during the various roles they played in the intervention. This process also shows the participants that there are specific methods that can be used effectively in a primary care setting to help chemically dependent patients and their families get into recovery programs.
5. If the time for this seminar is limited, the first module and much of the second module can be presented in a hand-out so that sufficient time can be allowed for the discussion of various strategies for confrontation and for the role play of the intervention.
6. It is very important to emphasize that the family can be helped even if the chemically dependent patient refuses help.
7. Frequently, after such a seminar some of the participants will request specific help for themselves or a family member. It is essential that you have resources you can refer them to or recommend to them.
8. This seminar requires considerable energy to present, especially if the role play intervention is done. It is much more enjoyable and easier to do if two or three people if two or three people share the responsibility.

REFERENCES

1. How to Use Intervention in Your Professional Practice. Minneapolis: Johnson Institute Books, 1987.
2. Clark, W.D.: Alcoholism: blocks to diagnosis and treatment. Amer. J. Med. 1981; 71:275-286.
3. Cyr, MG, Wartman, SA: The effectiveness of routine screening questions in the detection of alcoholism. JAMA 1988;259:51- 54.

APPENDIX A

RED FLAGS AND WHAT TO DO WITH THEM

Presenting Symptoms in Chemically Dependent Patients or Families

1. Sleep disorder
2. Chronic fatigue and depression
3. Nonspecific GI symptoms (diarrhea and /or gastritis)
4. Sexual dysfunction
5. Frequent accidents
6. Obesity
7. "My wife wants me to get a check-up"
8. Fights and altercations
9. Anxiety
10. Muscular pain
11. Absenteeism

Other History

1. Excessive smoking
2. Excessive coffee use
3. Family history of alcoholism
4. Family dysfunction
5. "Sick kids" (abdominal pain or headaches)
6. Nightmares in children
7. Frequent clinic visits
8. Psychosomatic illnesses in family members

Physical Examination

1. Odor of alcohol on breath
2. "The look" -baggy eyes and puffy face
3. Labile blood pressure
4. Slight tachycardia
5. Mild tremor
6. Cardiac arrhythmia
7. Enlarged liver
8. After shave-mouthwash syndrome

Laboratory

1. High triglycerides
2. Elevated GGT
3. Increased MCV
4. Elevated blood sugar with episodes of hypoglycemia
5. Low BUN
6. Elevated uric acid
7. LFTs elevated (usually late stage)

APPENDIX B

GETTING AT THE DIAGNOSIS

EARLY SIGNS AND SYMPTOMS (TO HELP DIAGNOSE)

Signs and symptoms	Value	Rating
Rationalization	1.5	
Conflict of values	3	
Changing patterns	**3.4**	
Arrests, including traffic charges	**4**	
Blaming	1.5	
Unpremeditated usage	**5**	
Personality changes	**4.5**	
Verbal abuse	**3.5**	
Uncomfortable with non-users	**3.3**	
Seeking/loving chemical highs	4.3	
Medicinal use	3	
Blackouts	**5**	
Preoccupation	4.5	
Tolerance changes (to chemical)	**2.7**	
Minimizing	2.2	
Urges to use	3.5	
Resentments	1.6	
Use at inappropriate times & places	5	
Hallucinations	5	
Seeking fellow users	3.1	
Defense of usage	**3.6**	
Attempts to control	**4.5**	

25 or more: Diagnostic
15-25: Probable
Less than 15: Nondiagnostic (but still possible because of severe denial)

Bold signifies easiest and quickest questions to help establish the diagnosis.

APPENDIX C

WHAT TO DO

I. Get Good Data
   A. From the Patient
   B. Lab Backup if Possible
   C. Spouse or Family Data

II. Confrontation -BE READY FOR THE WORST

III. Responses
   A. "I'll go to treatment" -Possible occasionally if patient trusts you
   B. "I don't believe it, but maybe"—Get a second opinion or AA
   C. "I can quit anytime"—Get a contract or agreement for abstinence or limited drinking with specific consequences
   D. Total denial
      1. Commitment
      2. Intervention
      3. Keep the door open
      4. Work with the family

THE FIVE KEY COMPONENTS OF AN INTERVENTION

1. **Gather together people who are very meaningful to the chemically dependent person and who are concerned about his/her alcohol/drug use.** These people will need first-hand knowledge of incidents and behavior related to the person's chemical use, such as blackouts, DWIs, loss of behavioral control, accidents, personal threats, or injury to self or others.

2. **Have those people make written lists of specific data about the person's alcohol/drug use and its effects, as well as their feeling responses.** This must be **first-hand** knowledge of incidents and behavior; gossip and second-hand information should be avoided.

3. **Have the concerned persons decide upon a specific treatment plan that they expect the chemically dependent person to accept.** The concerned persons must decide beforehand what type of help they want the alcoholic to get. This is the critical link in the intervention chain. The goal is not only to get the person to accept the help needed, but to accept this help **immediately** upon conclusion of the intervention session.

4. **Have the concerned persons decide beforehand what they will do if the chemically dependent person rejects all forms of help.**

5. **Meet as a group with the chemically dependent person and present the data and recommendations in an objective, caring, nonjudgmental manner.** A caring and nonjudgmental manner is crucial to the intervention process. Those who can't control their anger at the time of the intervention shouldn't participate.

APPENDIX D

"COMFORTABILITY AND COMPETENCY SCALE"

The following is a brief questionnaire to help assess your "comfortability" and competency in managing chemically dependent patients. For each question, use the scale below:

1	2	3	4	5	6	7	8	9	10
Not comfortable (competent)			Moderately comfortable (competent)			very comfortable (competent)			

Competence (1-10)	Comfort Level (1-10)	
______	______	(1) Identifying patients at high risk from the history.
______	______	(2) Identifying families at high risk from the history.
______	______	(3) Identifying patient at high risk from the physician examination.
______	______	(4) Identifying families at high risk from the physical examination.
______	______	(5) Obtaining a history to confirm the diagnosis of chemical dependency.
______	______	(6) Ordering appropriate laboratory tests to aid in the diagnosis.
______	______	(7) Confronting the patient with a suspected diagnosis of chemical dependency.
______	______	(8) Confronting the family with a suspected diagnosis of chemical dependency.
______	______	(9) Evaluating the possible treatment options.
______	______	(10) Doing a formal intervention to motivate patients to enter treatment.
______	______	(11) Referring patients to A.A.
______	______	(12) Referring family members to Al-Anon or Adult Children of Alcoholics.

From the above list, please list the three most important blocks to your working with chemically dependent/alcoholic patients

1. Most important ______________________________

2. ______________________________

3. ______________________________

Michael F. Fleming, MD MPH

Alcohol and Drug Withdrawal — Medical Management

CONTENTS

Page
Curriculum Example Description 103
Appendices:
Alcohol Detoxification Protocol 105
Pretest on Alcohol Withdrawal 110
Post-Test on Alcohol Withdrawal 111

Michael F. Fleming MD, MPH
Department of Family Medicine
University of Wisconsin
777 South Mill Street
Madison, WI 53715
(608) 263-9953

ALCOHOL AND DRUG WITHDRAWAL — MEDICAL MANAGEMENT

III. Context:

An educational program was developed for nursing staff, medical students, residents, and faculty at the University Hospital in Madison, Wisconsin. The program consists of six hours of teaching for nurses, two hours for medical students, and two hours for residents and faculty. It is expected these programs will be repeated on an annual basis.

IV. Rationale:

Alcohol and drug withdrawal are common medical problems in the hospital setting. This problem is commonly seen on general medical services, surgical areas, as well as in intensive care units. Recognition and early management can reduce the morbidity and mortality associated with alcohol and drug withdrawal. This is particularly important when patients have additional medical problems such as cardiac events, trauma, and infection. It is important to educate nurses, medical students, housestaff and faculty who care for these patients.

V. Objectives:

1) Nurses will have a basic understanding of recognition, diagnosis, treatment of alcohol and drug withdrawal.
2) Nurses will be able to use a modified version of the selective severity scale (see Appendix A).
3) Medical students will be able to recognize, complete a risk assessment profile, and write the initial orders for patients requiring alcohol and drug medical detoxification.
4) House staff and faculty will be able to recognize alcohol withdrawal, perform an alcohol withdrawal risk assessment profile, and manage patients in alcohol and drug withdrawal.

VI. Instructional Strategies:

1) Implementation of alcohol withdrawal treatment protocol (See Appendix A).
   - A) Incorporate treatment protocol into medical manual provided to new housestaff. Familiarize new housestaff as to the contents of the protocol during the annual orientation program for new residents.
   - B) Place a copy of treatment protocol on all medical units in the hospital and make nurses aware of location of protocol.
   - C) Publicize successful use of the protocol in the management of patients alcohol withdrawal.
2) Education of Health Professionals.
   - A) Nursing Staff--Provide nursing staff with a six-hour program to assist them in the recognition of alcohol problems and management of alcohol withdrawal. The program was developed by a team of health professionals (nurse-clinician, pharmacist, social worker, and physician). The total program will be offered at three different times to give a large number of nursing personnel the opportunity to attend the program. The program will be presented by faculty and nurses of the University of Wisconsin.
   - B) Medical Students--Two presentations will be conducted during their third year medical clerkship to maximize the clinical applicability of the program. The program will be presented four times per year to approximately 40 students for each session.
     1. Session 1--The presentation is structured as follows:
        10 minutes: recognition of alcoholism
        10 minutes: alcohol withdrawal risk assessment
        10 minutes: stages of withdrawal and physiological effects
        10 minutes: review of the treatment protocol
        20 minutes: case presentation of a patient in alcohol withdrawal
     2. Session 2--A second program is planned to deal with non-alcohol drug withdrawal. As with the alcohol talk the presentation on drug withdrawal will occur four times per year. The presentation is structured as follows:
        15 minutes: recognition and treatment of barbiturate and benzodiazepine withdrawal
        10 minutes: cocaine withdrawal
        10 minutes: opiate withdrawal
        10 minutes: other drugs
        15 minutes: case presentation of a patient experiencing withdrawal from multiple drugs
   - C) House staff and faculty program--These two programs will be given once per year to medical, psychiatry, and family medicine residents and faculty during a weekly grand rounds activity. The programs will be presented to the three specialties separately with each of the two programs being given three times each year.
     1. Session 1: alcohol withdrawal
        5 minutes: historical review of alcohol withdrawal and treatment
        10 minutes: alcohol withdrawal risk assessment
        10 minutes: physiology and stages of withdrawal
        10 minutes: treatment of withdrawal with benzodiazepines
        10 minutes: management of the complications of alcohol withdrawal
        10 minutes: case presentation
     2. Session 2 - non alcohol withdrawal
        10 minutes: recognition and treatment of barbiturate andbenzodiazepine withdrawal
        10 minutes: cocaine withdrawal
        10 minutes: opiate withdrawal
        10 minutes: other drugs
        10 minutes: case presentation of a patient experiencing withdrawal from multiple drugs

VII. Instructional Materials

A. Slides (available on request)

B. Overhead materials (available on request)

C. Hand-out materials (see appendix A)

VIII. Evaluation Strategies

A. Evaluation of Educational program

1) An evaluation will be performed at each session using a standard evaluation format.

2) A pre-test and post-test will be administered to each group. The pre-test will be given at the beginning of each session, and a post-test one week later.

3) A patient management problem is in the planning stages using a computerized format.

4) Nurses, medical students, residents, and faculty will be surveyed at the end of the first year to determine if they know of the existence of the alcohol withdrawal treatment protocol, whether they have used it, and whether it has been helpful in the management of patients in withdrawal.

5) A medical record audit will be conducted of all patients with a discharge diagnosis of alcohol withdrawal for the six months following the completion of the first year of the educational program (July 1988 through December 1988). A baseline medical record audit was conducted on 20 patients in May 1987 prior to the development of the treatment protocol and the educational program (results available on request).

IX. Organizational Constraints

1) Most of the organizational constraints have been overcome in the past year. The educational program for the nurses begins April 1989 and will be repeated in June and November. General Medicine has agreed to give two hours during the medicine clerkship to discuss alcohol and drug withdrawal with the medical students. The chief residents in medicine, psychiatry and family medicine have agreed to give two hours per year for their house staff on this issue. The faculty have also consented to utilizing grand rounds to discuss alcohol and drug withdrawal. The hospital policy committee adopted the treatment protocol into their health policy manual in April 1988.

X. Pilot Presentations

1) Medical students—A presentation on alcohol withdrawal was conducted to 25 medical students on February 25, 1988 and June 15,1988. The general evaluations were positive with a mean score of 4.2 for the five categories (highest possible score was 5). The pre-test post-test measures demonstrated increased level of knowledge.

2) Residents and faculty in medicine--A presentation was given to 15 residents and 10 faculty on alcohol withdrawal on December 15, 1987. A general evaluation suggested the program was useful and should be repeated on an annual basis.

3) Residents and faculty in family medicine--A presentation was made on January 14, 1988 to 12 faculty and 10 residents. A general evaluation of the program was positive and it will included as part of the resident curriculum on alcohol and drug problems.

94

APPENDIX A

ALCOHOL DETOXIFICATION PROTOCOL

Revised May 31, 1988

Mike Fleming, MD, Assistant Professor, Famiy Medicine

Vernon Hunt, MD, Associate Professor of Medicine (CHS)

Detoxification Protocol for Ethanol

A. Nursing care--see separate nursing assessment protocol.

B. No restrictions on fluid intake or food, with the exception of stimulants such as coffee, tea or cola. Patients should be on a high-calorie, high-carbohydrate diet.

C. IV fluids--should be administered to all patients in Stage III withdrawal and to most patients in Stage II withdrawal. D5, half normal saline should be used; potassium and/or magnesium may need to be replaced.

D. Heparin lock (for emergency access only), keep in until you are sure patient will not progress to Stage II or III withdrawal.

E. CBC, Liver Function Tests, electrolytes, Mgee, Prothromsin time, Chest x-ray, ECG, Cr, Blood alcohol level, urine drug screen should be ordered on all patients.

F. Restraints should be available at the bedside for any patient who is at high risk for Stage II or III withdrawal. Patients who develop Stage II or III withdrawal need either close observation by a family member or nursing staff, or should be restrained. A body restraint such as a poesy will be adequate in most cases.

G. Medications

1. Multivitamins, 1 tab daily.
2. B complex vitamins, 1 cc, and thiamine HC1, 100 mg IM q days times three.
3. Magnesium sulfate, 1 gm IM q 6 hours x 4 doses if history of withdrawal seizure, if high-risk for Stage III withdrawal, or if initial serum Mg
4. Atenolol, 50 mg PO BID x 4 days if pulse greater than 100 on admission (Kraus 3 1985).
5. Antiemetics.
   a. Prochlorperazin (Compazine) - 25 mg every 4 hours IM PRN nausea (use carefully in patients at risk for withdrawal seizures as phenothiazines lower the seizure threshold).

   or

   b. Hydrozyzine (Vistaril) - 50 mg every 4 hours IM PRN nausea.
6. Benzodiazepines
   a. Diazepam.

   Diazepam 20 to 20 mg PO q 2 hours until patient is sedated - avoid using diazepam IV unless patient is vomiting. The key to the protocol is to keep patients sedated but arousable. 50% will be controlled with a loading dose of 60 mg and not require further medication for control of symptoms.

   For patients who have progressed to Stage II or III withdrawal before receiving adequate doses of benzodiazepines, diazepam may be given q 30 minutes IV until patient is sedated. It is not unusual for such patients to require 200 mg of diazepam in the first twenty four hours.

   Patients who require more than 200 mg of valium should be supplemented with haldol and or lorazepam to reduce the risk of aspiration pneumonia.

   Due to the long half-life of diazepam, it is not necessary to taper valium over 72 to 96 hours.

   b. Lorazepam

   For patients with end stage liver disease and in patients who require more than 200 mg of valium for control of symptoms, lorazepam may be used instead of diazepam. The initial dose of lorazepam is 5 mg PO q 2 hours until patient is sedated. Lorazepam may be given q 30 minutes for patients who are severely agitated.

   Once the patient is adequately sedated give 2 to 4 mg q 4 hours PO over the the next 24 hours. Taper the lorazepam over the next 3 days by decreasing the dose used in the first 24 hours by 1/3 each day.
7. For severe agitation and patients who are not controlled with valium or lorazepam, give 2 to 10 mg of haloperidol (Haldol) IM q 1 to 2 hours. It may be necessary to use 20 mg/24 hours during severe Stage III withdrawal.
8. Patients who are at high risk for alcohol withdrawal seizures or who are dependent on benzodiazepines may be better withdrawn using phenobarbital. Withdrawal from Zanax can be as severe as withdrawal form alcohol and seizures are common (see separate barbiturate protocol).

Medical Withdrawal From Sedative Hypnotic Drugs Other Than Alcohol

1. Severity of withdrawal depedent on half life and potency
   a. High-risk sedatives include short-acting benzodiazepines such as Alprazalam (Zanax) and triazolam (Halcion), phenobarbital, quaaludes, and gluthethamide (Doriden).
   b. Moderat-risk drugs include meprobamate (Equanil), diazepam (Valium), chlordiazepoxide (Librium), lorazepam (Ativan).
2. Withdrawal symptoms are similar to that of alcohol. Muscle cramping may be a prominent symptom in benzoidiazepine withdrawal. Patients in valium withdrawal have been known to have severe abdominal pain which may mimic a surgical abdomen. Withdrawal symptoms from long-acting benzodiazepines may not develop for five to ten days after cessation of the drug.
3. Advantages of phenobarbital
   a. excellent anticonvulsant--most effective drug for prevention of alcohol withdrawal seizures;
   b. excreted unchanged in urine, not dependent on hepatic transformation;
   c. low abuse potential;
   d. gives a smooth withdrawal.
4. Protocol
   a. Initial dose--Sodium Luminal 120 to 240 mg I.M.
   b. Phenobarbital P.O. 30 mg q.i.d. times three days, then 15 mg q.i.d. times two days;
   c. Supplemental doses of Sodium Luminal (60 to 120 mg Q 8 hours PRN) may be administered for agitation or development of Stage II or III withdrawal.

JUSTIFICATION OF PROTOCOL

I. General Treatment Principles of Alcohol Withdrawal

Detoxification is the process by which an individual who is physically dependent upon alcohol is gradually withdrawn from alcohol by administering decreasing doses of a cross tolerant drug, such as diazepam. There is increasing evidence that receptors that mediate the effects of alcohol, benzodiazepines, and barbiturates are located in close proximity on the gamma-aminobutyric acid (GABA) receptor (Kolata 1986). This may explain why benzodiazepines and barbiturates have been found to be the most effective medications for alcohol withdrawal.

The most difficult problem in the management of alcohol withdrawal for physicians not familiar with this problem is the large variation in amount of medication needed to prevent the complications of alcohol withdrawal. While the detoxification protocol provides specific dosage recommendations, the amount of medication required by different patients may vary by ten-fold (Sellers 1983). The following basic principles should be helpful in assisting nurses, housestaff and faculty in the management of alcohol withdrawal.

A. There are three stages of withdrawal that have been noted to occur. The treatment and clinical significance of each is different, so it is important physicians and nurses be able to recognize these stages (Benferado, 1981, pg 14; Thompson 1978).

Stage I withdrawal is commonly called minor withdrawal. It is characterized by restlessness, anxiety, sleeping problems, agitation and tremor. Patients may also develop a tachycardia, a low grade febrile response, diaphoresis, as well as an elevated systolic and diastolic blood pressure.

Stage II withdrawal is commonly called major withdrawal. It is characterized by the presence of signs and symptoms of Stage I plus auditory or visual hallucinations. The Stage I signs are also more severe. The tremor may involve the whole body rather than a simple coarse tremor of the hands. The pulse is frequently over 100 and diaphoresis more pronounced.

Stage III withdrawal is commonly called delirium tremens. The major diagnostic criterion for this stage is the presence of delirium. The Stage I symptoms are usually severe as in Stage II. A patient in delirium tremens may or may not have hallucinations. The delirium in alcohol withdrawal commonly manifests itself by disorientation to time, place, and person, global confusion, and inability to recognize familiar objects or persons.

A scoring system to more objectively define the severity of alcohol withdrawal has been developed by a group in Toronto (Shaw 1981) and will be discussed in the nursing assessment portion of this protocol.

B. Treatment of withdrawal symptoms with sedatives and tranquilizers has shown to decrease the incidence of withdrawal seizures, the incidence of delirium tremens, and associated morbidity and mortality (Sellers 1976). The goals of treatment are as follows:

1. relief of symptoms--tremulousness, agitation, anxiety, sleep disturbances, and other manifestations of autonomic hyperactivity;
2. prevention of the development of Stage II or III withdrawal;
3. prevention of seizures;
4. minimize chance of a new dependency problem on the medication used for withdrawal; and,
5. minimize toxicity of medication used for detoxification.

The most widely used medications for the treatment of alcohol withdrawal are the benzodiazepines. Of the treatments used prior to the development of the benzodiazepines, such as choral hydrate, paraldehyde and alcohol, only the barbiturates are used with any frequency (Smith 1976).

Clinical trials have shown that all of the benzodiazepines are equally effective in the treatment of withdrawal. They have been found to be more effective than placebo or no drug therapy in decreasing anxiety, restlessness, tremor, seizure and the prevention of the development of Stage II and III withdrawal (Sellers 1983).

As chlordiazepoxide (Librium) and diazepam (Valium) are long-acting they have been found to provide a smoother withdrawal than short-acting benzodiazepines such as oxazepam (Serax) or lorazepam (Ativan). The major principle to follow in the use of these medications is to use high dosages in the first 24 to 48 hours with gradual tapering over the next three to four days.

These drugs are useful at preventing Stage II or III withdrawal only when used in high doses early, before the patient develops seizures, hallucinations, or delirium. Medication is much less effective once major withdrawal symptoms have developed.

C. Stage I withdrawal symptoms will usually begin five to eight hours after the last drink of alcohol. Symptoms of Stage II and III withdrawal may begin as quickly as 24 hours after the last drink, or be delayed for 72 hours.

The severity and onset of alcohol withdrawal can be predicted with reasonable certainty by considering the following factors: 1) age; 2) daily consumption; 3) duration of excessive drinking; 4) drinking frequency; 5) history of tremors with abstinence; 6) history of withdrawal seizures; 7) history of Stage II or III withdrawal; 8) poor nutritional status; 9) presence of acute medical problems, particularly infections; and 10) polyaddiction, especially with the barbiturates.

Patients with the following characteristics are likely to develop Stage II or III withdrawal if not treated with large doses of benzodiazepines as soon as they develop withdrawal symptoms:

1. age over 40
2. daily consumption one-fifth of liquor
3. drinks around the clock to maintain a steady blood alcohol level
4. excessive drinking over 10 years
5. development of tremulousness and anxiety within six to eight hours
6. history of seizures, hallucinations, delusions with alcohol withdrawal
7. presence of an acute medical problem such as pneumonia
8. alcohol level of 300 mg or greater on admission

As alcoholics may not give an accurate history about consumption, obtaining a history from a friend or family member is essential in patients who are at risk for withdrawal.

D. Polyaddiction occurs in over half the patients admitted to alcohol treatment centers. A detailed drug history, including types of substances used, amount, most recent usage, and route of entry is important. A urine drug screen should be obtained on all patients.

Addiction to alcohol and long-acting benzodiazepines complicates the management of alcohol withdrawal. Larger doses are frequently required to control the symptoms of alcohol withdrawal and serious withdrawal symptoms can develop up to 14 days following the last dose of benzodiazepines.

Polyaddiction to alcohol and barbiturates is uncommon currently, but when present results in more severe withdrawal symptoms.

9C

II. Explanation of Treatment Protocol

NUTRITION

Vitamins and Thiamine

Alcoholics are frequently depleted of B Complex vitamins. Multivitamins are commonly given, though their value is unproven. Thiamine is recommended before any intravenous glucose is administered. Multivitamins with folate and thiamine should be given orally or intramuscularly daily for three days. Vitamin K should be given if the Protime is elevated.

Magnesium Sulfate

Total body stores of magnesium are usually depleted in alcoholics; 1,000 mg depletion of Mg is not unusual. While the clinical importance of this observation is not clear, replacement may decrease the risk of withdrawal seizures and the development of delirium tremens. One (l) amp of magnesium sulfate contains 98 mg of magnesium.

Mooney (1982) recommends 4-6 amps of magnesium sulfate be given in the first 24 hours to patients at high-risk for withdrawal seizures or major withdrawal. Magnesium may be given IM or IV. Intramuscular injection is painful but safer and considerably less expensive than the IV route. The major problem with intravenous infusion of magnesium sulfate is hypotension. Since most patients in withdrawal are hyperactive, this is rarely a problem.

HYDRATION

Hydration with intravenous fluids may be required particularly in Stage III withdrawal. Patients with mild withdrawal symptoms can usually be managed without intravenous fluids. Alcoholics have altered sodium water metabolism, so overhydration can easily develop. Fluid and electrolyte status need close monitoring in Stage III withdrawal.

ANTIEMETICS

Promethazine (Pheneragan) or Prochlorperazine (Compazine) can be used for treatment of nausea, although this is usually not necessary when patients receive adequate dosages of benzodiazepines. However, since phenothiazines lower the seizure threshold, these drugs should not be used in someone with a history of withdrawal seizures. An alternative drug that does not appear to alter the seizure threshold is hydroxyzine (Vistaril).

PHARMACOTHERAPY

Diazepam should be started as soon as a patient begins to develop signs of withdrawal. Recent work by the group at the Addiction Research Center in Toronto (Sellers 1986) suggests that a loading dose of diazepam simplifies treatment and is equally effective to usual method of administering benzodiazepines every 4-6 hours for 72 to 96 hours.

Diazepam is given orally whenever possible. At the onset of withdrawal symptoms, 20 mg of diazepam is given. Two additional doses of diazepam are administered at two-hour intervals for a total dose of 60 mg. Their data indicate that 50% of patients require no further medication due to the long half life of diazepam. Approximately 40% of their patients required additional doses to control symptoms and to prevent the development of Stage II or III withdrawal. The additional doses are given every two hours until the symptoms of withdrawal are controlled. Once the patient's symptoms are controlled, additional diazepam may not be necessary due to the long half life of diazepam.

The frequency of administration of diazepam depends on the severity of withdrawal at the time of admission. Patients admitted in early Stage I withdrawal can be dosed every two hours until adequate sedation is obtained. Usually only three doses are needed. Patients admitted in Stage II or III may need to be dosed every 30 minutes or less. Patients admitted with Stage III withdrawal may require as much as 200 mg in the first 12 hours.

Lorazepam may be used rather than diazepam in patients with cirrhosis, with evidence of portal hypertension, with hypoalbuminemia and altered clotting studies, or in patients not controlled with diazepam. However, due to its short half life, lorazepam needs to be given more frequently and management of withdrawal with it is more difficult. Patients need to be monitored frequently for worsening of withdrawal symptoms as these symptoms will fluctuate when short-acting benzodiazepines are used. Patients need to be tapered off lorazepam, therefore they need to be monitored for three to four days after the withdrawal symptoms have cleared and the dosage systematically decreased.

Patients requiring more than 200 mg of diazepam should be supplemented with haloperidol and short-acting benzodiazepines to reduce the chance of over sedation and aspiration pneumonia. As the withdrawal symptoms begin to resolve, patients may become overly sedated as diazepam and its metabolites are released from receptor sites, lipid deposits, and storage areas in the liver.

TREATMENT OF WITHDRAWAL SEIZURES

Alcohol withdrawal seizures occur 12 to 36 hours after the last drink. They usually precede the development of delirium tremens or Stage III withdrawal by 24 hours. Withdrawal seizures typically are grand mal, last less than five minutes and are singular. Seizures lasting more than 15 minutes are unusual. If the patient is receiving adequate doses of diazepam, a single seizure may not require additional medication. Patients receiving lorazepam should be given 10 to 20 mg of IV diazepam. While phenytoin has not been shown to be of value in the prophylactic prevention of withdrawal seizures, it can be useful if patients develop status seizures. As with other seizures a loading dose is necessary. Patients who develop status should be evaluated for intracranial pathology (Sampinger 1974; Rothstein 1973).

TREATMENT OF AGITATION AND USE OF RESTRAINTS

Patients in alcohol withdrawal are afraid, anxious, and easily misinterpret their environment. The beeping of a cardiac monitor, the noise of an oxygen mask or respirator, or the general noise level of the hospital are very upsetting to someone in withdrawal, and frequently result in severe agitation. While restraints are sometimes necessary, these usually increase agitation levels several-fold. Patients report restraints as the most frightening aspect of withdrawal.

Alcohol treatment centers rarely, if ever, use physical restraints to control the agitated patient in withdrawal. This is in sharp contrast to general medical or surgical services where physical restraints are frequently necessary to prevent injury to the patient, staff, and other patients. The reasons for this difference include nursing staff who have experience "talking patients down," smaller staff-patient ratios, a quiet peaceful environment, locked units where patients can wander, and absence of patients with other medical or surgical problems.

While one cannot duplicate the environment of an alcohol treatment facility in the ICU, medical or surgical wards, one can use some of these techniques to minimize the need for restraints. The hospital restraint policy requires a nurse to observe a patient in four-point restraints every 15 minutes.

NURSING MANAGEMENT ALCOHOL WITHDRAWAL

Identification of Stages & Intervention

SYMPTOMS	1 point: STAGE I	2 points: STAGE II	3 points: STAGE III
ONSET	5-8 hrs. p last drink	1-3 days p last drink	72-96 hrs. p last drink
ANXIETY	"Inner anxiety;" nervous	Irritable-tearful-fearful	Emotionally out of control
AGITATION	Restless; loss concentration easily disturbed; reactive	Fidgety; can't sit still; picking; may pace	Hyperactive; can't contain
PULSE	Tachy: 100-120	120-140	Above 140; may become irregular
TEMPERATURE	Slight increase 37.2-37.7	37.7-39.1	39.1-40.5 & over
RESPIRATIONS	20-24	24-30	30 & over
B/P	Unstable & elevated; DBP>100 SBP<160	Both systolic & diastolic increased DBP>100 SBP>160	Severe hypertension: DBP>110 SBP>180 Severe hypotension: DBP>60 SBP>100
TREMOR	Mild; may not be visible--touch fingers; note tongue-eye movement	Visible hand/arm; have pt. extend U.E.; tongue tremor & constant eyeball movement	Exaggerated--may be total body movement
DIAPHORESIS	Palms/forehead damp-slight	Beads of sweat-obvious.	Drenching sweats
EATING DISTURBANCE	Not hungry but picks & eats over 50%	Less than 50% with encouragement	Less than 10%
G.I. DISTRESS	Mild N-V-D (any or all)	Moderate N-V-D	Severe N-V-D; may be incont. stool
SLEEP DISTURBANCE	Difficulty settling; up 1-3 times	Awake half the night	Completely sleepless
CLOUDING SENSORIUM	Can't do serial 7 subtract. Knows correct date but not sure; generally coherent	Disoriented tire by two days; Confusion; harder to reorient	Can't identify significant others. Disoriented time, place
HALLUCINATIONS	Not present	Mild auditory/visual	Auditory/visual; may be fused or non-fused
CONVULSIONS	Usually not present; occur 12-36 hours. p last drink	"Rum Fits" 5 min. & subside Grand mal seizure: tonic spasms/clonic jerking PRECEDE DELIRIUM TREMENS BY 24 hrs.	Severe; reoccurring

1. Identification of potential alcohol withdrawal in the hospitalized patient is vital in prevention and depends on nursing interview and assessment skills in the majority of instances.
2. WITHDRAWAL FROM ALCOHOL IS A CRITICAL MEDICAL EMERGENCY.
3. IF MEDICATED ADEQUATELY, MOST WITHDRAWAL STOPS AT STAGE II!

NURSING INTERVENTION

STAGE-1

Assess/document S/S.

Notify M.D. if score >5.

Medicate according to protocol & physicians orders.

Hep well secured.

Diffuse agitation & anxiety:
  walk/talk. Supportive;
  firm; allow pt. some
  control to use energy.

Treat symptomatically:
  Fluids: O.J. has K.
  Antiemetics.

Review labs:
  Blood alcohol level
  CbC/LYTEA/LFT's (hepatitis)
  Drug screen; mixed abuse
  Ammonia level
  Magnesium
  Glucose
  Pro time.

STAGE-2

Assess/document S/S.

Notify M.D. if score >10.

Notify house staff protocol.

Medicate as required for all symptoms.

SYMPATHETIC STORM requires SYMPATHETIC CARE.
  Talk down-quiet-orient
  Nonjudgemental
  Re-assuring
  Pad side rails
  Use restraints ONLY if necessary to prevent injury - NOT for convenience; try posey, light restraints before leathers

DECREASE VISUAL-AUDITORY STIMULATION.
  Quiet room; avoid T.V.
  Well lighted, decrease shadows/fear
  Limit activity & numbers of people
  PROVIDE CALM CARE

Support & educate family.

Frequent v.s. 15-30 min.

STAGE-3

ONCE D.T.'S OCCUR-LITTLE CAN BE DONE TO ALTER!

Acute Stage: Notify M.D.

PUSH ICU BED FOR INITIAL ONSET STAGE-3!

Medicate: sedation
  fever
  B/P
  Pulse

Oxygen

Suction available

Cooling Blanket

1:1 Nursing Care

Restraints/Padded rails

Maintain pt. dignity: foley/rectal tube

Family support/reassure

Symptomatic treatment of complications:
POTENTIAL
  SHOCK
  STROKE
  ALKALOSIS
  CARDIAC ARRHYTHMIAS:
    heart attack
  FLUID/ELECTROLYTE IMBALANCE
  SUDDEN DEATH FROM CARDIAC
    RESPIRATORY FAILURE

REFERENCES

1. Kraus, ML, Gottlieb, LD, Horwitz, RI. Randomized Clinical Trial of Atenolol in Patients with Alcohol Withdrawal. *N Engl J Med*, 1985; 313: 218-222.
2. Kolata. New drug counters alcohol intoxication. *Science* 1986; 234-1198-9.
3. Sellers, EM, Naranjo, CA, Harrison M. Diazepam Loading: Simplified Treatment of Alcohol Withdrawal. *Clin Pharmacol Ther* 1983; 34:822-826.
4. Benferado J. *Alcohol and Other Drug Abuse Manual*. University of Wisconsin. Fourth Edition Revised 1981.
5. Thompson WL. Management of Alcohol Withdrawl. *Arch Intern Med* 1978; 138:207-210.
6. Shaw JM, Kolesar GS, Sellers EM, et al. Development of Optimal Treatment Tactics for Alcohol Withdrawal. *J Clin Psychopharmacol* 1981; 1(6): 382-390.
7. Sellers EM, Kalant H. Alcohol Intoxication and Withdrawal. *N Engl J Med* 1976; 294:757-761.
8. Smith RS, Morin R. A comparison of the clinical effectiveness of Librium and phenobarbital and the management of sedative withdrawal. Presentation. Seventh Annual Medical Scientific Session, National Council on Alcoholism, Washington, D.C., Spring 1978. Washington, D.C.: National Council on Alcoholism, 1978.
9. Mooney AJ 3rd. Alcoholism Withdrawal protocol. Unpublished. Statesboro, Ga.: Willingway Hospital, 1982.
10. Sellers EM, Naranjo CA. New Strategies in the Treatment of Alcohol Withdrawal. *Psychopharmacol Bull* 1986; 22:88-91.
11. Sampinger R, Iber FL. Diphenylhydantoin Control of Alcohol Withdrawal Seizures. *JAMA* 1974; 230:1430-1434.
12. Rothstein E. Prevention of Alcohol Withdrawal Seizures: The Role of Diphenylhydantoin and Chlordiazepoxide. *Am J Psy* 1973; 130:1381-1384.

PRETEST ON ALCOHOL WITHDRAWAL

Developed by Michael Fleming, MD

October 15, 1988

1. There at least eight variables that assist the clinician in estimating the likelihood an alcoholic patient will develop signs and symptoms of alcohol withdrawal (eg, history of symptoms with previous alcohol withdrawal). List as many of these factors as you can.

   1.

   2.

   3.

   4.

2. List the major signs and symptoms of alcohol withdrawal.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

3. A patient with a history of alcohol withdrawal seizures should be given Dilantin to prevent recurrence of seizures when such patients are detoxed from alcohol.

   True False

4. In addition to treating the symptoms of alcohol withdrawal and making the patient more comfortable, the primary reason for using benzodiazepines in alcohol withdrawal is to prevent the development of Stage II and III withdrawal.

   True False

5. The short-acting benzodiazepines (eg, lorazepam) are preferred over the long-acting (eg, chlordiazepoxide and diazepam) for the medical detoxification of alcohol.

   True False

6. Alcohol withdrawal seizures usually occur within 36 to 72 hours after the blood alcohol level falls to zero.

   True False

7. Patients in alcohol withdrawal who are severely agitated should be placed in a dark environment with restraints to calm them down.

   True False

8. Phenobarbital is an effective drug for use in alcohol withdrawal with a wide margin of safety.

   True False

101

POST-TEST ON ALCOHOL WITHDRAWAL

Developed by Michael Fleming, MD

January 15, 1988

1. There at least eight variables that assist the clinician in estimating the likelihood an alcoholic patient will develop signs and symptoms of alcohol withdrawal (eg, history of symptoms with previous alcohol withdrawal). List as many of these factors as you can.

   1.
   2.
   3.
   4.
   5.
   6.
   7.
   8.

2. List the major signs and symptoms of alcohol withdrawal.

   1.
   2.
   3.
   4.
   5.
   6.
   7.
   8.
   9.
   10.

3. A patient with a history of alcohol withdrawal seizures should be given Dilantin to prevent recurrence of seizures when such patients are detoxified from alcohol.

   True False

4. In addition to treating the symptoms of alcohol withdrawal and making the patient more comfortable, the primary reason for using benzodiazepines in alcohol withdrawal is to prevent the development of Stage II and III withdrawal.

   True False

5. The short-acting benzodiazepines (lorazepam) are preferred over long acting agents such as chlordiazepoxide and diazepam for medical detoxification of alcohol.

   True False

Name ____________________

Address ____________________

____

____

Phone Number ____________________